

UNICEF Health and Nutrition Programmes in Somalia

**Final Report of an
Evaluation Funded by UNICEF & USAID**

June 2001

Development Solutions for Africa
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Table of Contents

1	Executive Summary	1
2	INTRODUCTION	4
3	TERMS OF REFERENCE AND METHODOLOGY	5
4	EVALUATION FINDINGS	8
4.1	Policy and Co-ordination.....	8
4.2	Management and Organisational Issues at UNICEF Somalia	9
4.2.1	Staffing Issues.....	10
4.2.2	PHC and MCH Management and PHC Guidelines and Standards	12
4.3	Health and Nutrition Activities and Results	12
4.3.1	Strengthening the Health Service System	12
4.3.2	Maintaining/Increasing the Current Immunisation Coverage.....	23
4.3.3	Improving Reproductive Health Services	28
4.3.4	Preventing Outbreaks of Infection	28
4.3.5	Preventing and Reducing Malnutrition among Women & Children.....	29
4.4	Addressing Health & Nutrition Needs of Somali Children & Women	33
5	LESSONS LEARNED AND RECOMMENDATIONS.....	35
5.1	Policy, Strategy and Plans	35
5.2	Organisation, Management and Human Resources	36
5.2.1	Supervision and Monitoring	37
5.2.2	PHC and MCH Guidelines and Standards	38
5.3	Information Systems.....	38
5.3.1	Management and other Indicators.....	39
5.3.2	Geographic Information Systems (GIS)	39
5.4	Health Sector Reform and Health Care Financing	40
5.5	Specific Programmes.....	41
5.5.1	EPI and NIDS	42
5.5.2	Health Information Campaigns and Community Participation.....	43
5.5.3	Nutrition.....	43
5.5.4	Reproductive Health (RH)	44
5.5.5	Distribution of Drugs and Supplies.....	44
6	NEW INITIATIVES	45
6.1	Human resource development/capacity-building.	45
6.2	Community mobilisation and participation.	47
6.3	Initiatives for the Private Sector	48
6.4	Integration of a Geographic Information Systems (GIS) into the HMIS.....	49
6.5	Selection of Partners and Contracts.....	49
7	CLOSING COMMENT	50

Annex 1:	Documents Reviewed
Annex 2:	UNICEF's Partner Agencies and Project Agreements
Annex 3	Key Informants Interviewed
Annex 4	Evaluation Data Collection Instruments

Abbreviations

AAH	Aktion Afrika Hilfe
ANC	Ante Natal Care
COOPI	Co-operazione Internazionale
COSV	Co-ordinating Committee of the Organisation for Voluntary Service.
EC	European Commission
EPI	Expanded Programme for Immunisation
GM	Growth Monitoring
H&N	Health and Nutrition
HMIS	Health Management Information System
ICD	International Co-operation for Development
ICRC	International Community of the Red Cross
IMC	International Medical Corps
INGO	International Non Governmental Organisation
FT	Fixed Term Contract
MCH	Maternal and Child Health
MOH	Ministry of Health
MOH&L	Ministry of Health and Labour
MOSA	Ministry of Social Affairs
MSF	Medecins sans Frontieres
NE	North East Zone
NGO	Non Governmental Organisation
NW	North West Zone
OPD	Out-Patient Department
PHC	Primary Health Care
PO-H&N	UNICEF (Zonal) Health and Nutrition Officer
RPO	UNICEF Resident (Zonal) Project Officer
SACB	Somalia Aid Co-ordinating Body
SCZ	South and Central Zone
SHSC	Somalia Health Sector Co-ordination
SRCS	Somali Red Crescent Society
SSA	Special Service Agreement (SSA)
TBA	Traditional Birth Attendant
TFT	Temporary Fixed Term Contract
TOT	Training of Trainers
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organisation
WV	World Vision

1 EXECUTIVE SUMMARY

UNICEF plays a central role in the provision of primary health care in Somalia. In the past 5 years, UNICEF has shifted its focus from service delivery to the provision of technical assistance, supplies and other resources to other direct service providers or “partners”. Major partners are the Somaliland Ministry of Health and Labour (MOH&L) in the North West Zone, the Puntland Ministry of Social Affairs (MOSA) in the North East Zone and international and national non-governmental organisations (NGOs) in the South and Central Zone. The transition from emergency to development in the NW and the NE has offered new opportunities to gradually shift the overall responsibility of provision of health care to the administrations in place.

The problems of co-ordinating and supporting a large number of INGOs, local NGOs and different administrations in each Zone is an extremely complex task. More attention and resources should be given to the decentralisation of programmes, Zonal level co-ordination, increased supervision of activities and capacity-building. Increased emphasis on coordination, planning meetings in the Zones and a reduction of the field staff time in Nairobi is particularly important as the capacity-building of local administration and Somali-based organisations is given a higher programme priority.

UNICEF is the main supplier of **essential drugs and supplies** to the providers of health services in Somalia. While there have been problems with UNICEF’s Essential Drug Kit System, the kits still seem to be the most appropriate option. UNICEF has worked hard to resolve many of the problems, and during this evaluation, all facilities visited had received drug kits within the previous two months, and no expired drugs were found.

A major achievement has been the establishment of a regular supply of vaccines for the **Expanded Programme for Immunisation (EPI)**. The strategy of supporting partner agencies with cold chain equipment, supplies, vaccines and training has proven to be successful in achieving high immunisation rates in a very difficult setting. The combination of static and mobile sites is important for providing equity in vaccine access to nomads and dispersed populations as well as urban populations. “Piggy-backing” Vitamin A supplementation to EPI has resulted in dramatic improvements in coverage of this micronutrient. UNICEF has proven that the private sector and local NGOs can provide immunisations, and local authorities can be responsible for logistics. Some cold chain and other technical problems were noted during the evaluation, and it was also noted that EPI guidelines were not available in the field. Guidelines should be distributed, translated when necessary and referred to during training and supervisory visits.

The **National Immunisation Days for the Eradication of Polio (NIDs)** programme is both an opportunity and a threat to on-going EPI. A notable achievement is the very high immunisation coverage in the SCZ. However, partners have complained that NIDs has created problems by offering high rates of remuneration to personnel who normally conduct EPI for free and by completing plans without consultation with local partners. Planning for NIDs needs to involve all partners and should be on going throughout the year so that remuneration, logistics, reporting, etc. can be integrated with and improve on-going programmes.

UNICEF's **Nutrition and Reproductive Health Programmes** have been less successful. It is recommended that UNICEF reduce expenditure of scarce resources on ineffective interventions in these areas and focus on EPI, Essential Drugs, promotion of breastfeeding and community-based improvement of nutritional status, the distribution of micronutrients, training and capacity building.

Community mobilisation and participation: Somali communities have a strong tradition and their own way of managing household and group resources. UNICEF's future programmes should include the basic component of community mobilisation and capacity building. This component should also be part of other partner agreements and monitored by UNICEF field personnel.

Cost-sharing has been introduced in most of the health facilities in the NW and NE and in parts of the SCZ. A major short-coming of these efforts has been the failure to follow up on recommendations from the report on Health Financing and the Strategic Plan for the Health Sector in Somalia.

UNICEF has neither the mandate nor resources required to manage and assist implementing agencies to deliver a full range of basic health services to the entire population in each Zone of Somalia. UNICEF is already trying to accomplish too much with too few resources and needs to refocus and prioritise its interventions. While the health policy and strategic plan for Somalia are well formulated, the strategies to achieve programme objectives need to be carefully and explicitly adapted to the organisational and institutional contexts between and within each Zone. Health sector reform strategies and operational plans need to be more precisely formulated in terms of actual capacity and resources available. Priorities and targets need to be formulated separately for each Zone.

To support the development of a sustainable health care system, UNICEF should increase its promotion of stakeholder participation at all levels. In areas of stability like the NW and the NE, UNICEF's role should be to expand and improve the quality of stakeholder participation in planning, implementation and monitoring of health related services. At this time, the training of Somali health workers including local professionals should be done in-country, and should:

- Expand short-term training of local administrative, professional and auxiliary staff.
- Support the operation of existing, and establishment of new Zonal and Regional Health Training Centres and the training of a cadre of teachers and administrators to work in them.
- Expand training programmes to include administration, management and health planning and budgeting.
- Support the production of training and learning materials for managers, health professionals and auxiliary staff.
- Explore and identify opportunities and mechanisms to recruit Somali health professionals living outside the country. Expatriate Somalis should be considered as essential to the staffing of health training institutions in the Zones.

The private sector (including pharmacies) have been and will continue to be the major provider of health services. Policy and plans need to address the role and responsibilities of the private sector in the provision of safe, low cost drugs, accurate information to clients, and both curative and preventive services. They should address specific measures to protect the public from abuse, fraud and excessive costs and how public sector resources can be used to improve the services and products provided through private practitioners and suppliers of pharmaceuticals. Initiatives which could be taken to expand the scope of health sector development to the private sector include,

- Education and Training;
- Assisting authorities to develop guidelines for registration and certification;
- Assisting Somali health workers to create effective professional associations;
- The “Purchase” of services from established private services.

UNICEF and other donors also need to expand the scope of their institutional partners to include universities and other research and training institutions in developed and developing countries. This is particularly critical to the long-term success of capacity-building initiatives including the establishment of Health Training Centres. The experience of the past decade clearly reveals that the use of a highly collaborative approach among NGOs whose primary concern and skills are emergency interventions and the delivery of basic health services is complex, slow and costly. Another level of partnership is needed to move forward quickly on the development of administrative structures and educational institutions for the health sector.

2 INTRODUCTION

UNICEF's programme in Somalia was last evaluated in 1995. USAID, the major funding agency for UNICEF/Somalia, requested an external evaluation of the programme as a part of the 1999 – 2000 contract. In January 2001, Development Solutions for Africa was contracted by UNICEF Somalia to perform this evaluation.

The evaluation of programmes in Somalia must be conducted with the understanding that there are severe constraints on effectiveness and accountability specific to Somalia. The major constraints are security, staffing, and lack of basic demographic data. The scale and depth of these constraints makes issues of supervision and accountability dramatically different in Somalia as compared to most other countries.

The issue of security does not need to be reviewed in this report, except to say that lack of security is evident everywhere in varying degrees in different regions at different times. The lack of security makes it difficult for UN and other international organizations to recruit and retain qualified staff. Even during field work for this evaluation, time was lost when a former guard, recently fired for theft, threw a live hand grenade into an INGO (international non-governmental organisation) compound. This is but one example of the dangers of supervision and critical review of performance in Somalia.

Large numbers of Somali health professionals have emigrated during the past 15 years. The few who are left completed their professional training in the 1980s. The vast majority of staff in the health facilities do not have any official certification and their technical and professional qualifications are based on "self-reported competence." All nurses were trained between 1979 and 1986 as enrolled nurses and midwives. Auxiliary nurses, those with little or no formal training, perform most routine MCH services such as weighing mothers and children, maintaining the cold chain, and dispensing drugs and registering patients.

In view of the huge deficit in the number of Somali health professionals, expatriate professionals are recruited. However, the security situation and the restrictions it places on "quality of life" in Somalia, make it difficult for INGOs and other agencies to attract experienced and qualified medical and public health professionals. Funding for most projects is for a short duration –one year or less for most agencies, two years for most European Commission (EC) funded projects. Staff turnover is high in some agencies and contributes to the weakness of the "institutional memory" important in development work. Only a small number of those working in Somalia programs have had professional training and significant job experience in public health in developing countries. One may also add that the sociocultural context of Somalia – pastoralism and tribal and clan based systems - is very different from those of developed and most developing nations with agricultural and industrial economies and functioning national governments.

The staffing situation impacts not only on the quality of care offered in health facilities, but also on attempts to improve it. Expatriates responsible for training seldom have pedagogical skills, and the curricula adapted from other countries are based on the assumption that a health professional is being trained. The years of basic science, anatomy, physiology, pathology and pharmacy which form the basis of knowledge and a manner of approaching and defining problems is lacking in someone who has never had the opportunity for

professional training. The trainee's ability to understand, retain, and apply the training offered is limited by his or her lack of basic education.

Lack of security also constrains serious planning and evaluation activities which depend on reliable demographic data and facility/mobile unit catchment populations. The population estimates for Regions in Somalia show significant differences as illustrated in the table below for the NEZ.

Table. **Total population figures by region in North East Somalia** (as of mid-1998)

Name of region	UNDOS	UNICEF	WHO
Bari	290,528	171,090	295,815
Mudug	174,739	263,340	379,315
Nugal	105,244	105,120	165,390
Total	570,511	539,550	840,520

UN organisations' figures differ significantly. The World Health Organisation (WHO) figure for Mudug Region is 379,315 as compared with the United Nations Development Office for Somalia (UNDOS) figure of 174,739, i.e. the difference between the two figures is more than 204,000 -- i.e. the WHO figure is 117% greater than the UNDOS figure. The totals, for North East Zone, which is relatively secure, range from 539,550 (UNICEF) to 840, 520 (UNDOS).

Basically, the denominator in any calculation of coverage is unknown. And, as if it mattered with no denominator, the numerator is also questionable. Utilisation data are routinely inflated or just made up. Attempts to calculate coverage and impact with these data are mythical at best. UNICEF has attempted to compensate for routine data collection problems with Multiple Indicator Cluster Surveys. This is a sound approach but a great deal of complex analytical work and education is needed to integrate the results into the planning, management and evaluation of programmes.

3 TERMS OF REFERENCE AND METHODOLOGY

The Terms of Reference were jointly developed by USAID, UNICEF and Development Solutions for Africa. The specific objectives are:

- To determine the extent to which UNICEF Somalia health and nutrition activities met planned targets, coverage and strategies agreed and finalised by USAID.
- To determine, using data available and collected during the evaluation exercise, the extent to which UNICEF activities have adequately addressed the health and nutrition needs of Somali children and women in the target areas.
- To review UNICEF Somalia PHC and MCH management and PHC guidelines and standards and give recommendations on improvements or changes as necessary.

- To meet with NGO partners involved in MCH management and PHC activities to identify issues and problems that need to be addressed in order to improve health programming in Somalia.
- To identify the lessons that can be drawn from the evaluation and recommend how to incorporate these lessons in future health programme design and implementation.
- To recommend areas to be changed and/or strengthened in UNICEF health interventions (including EPI) in Somalia.
- To recommend new areas or methods of intervention in the health and nutrition sectors, especially for the emergency areas of the country.
- To facilitate at the end of the consultancy, a meeting to review, and revise as necessary, UNICEF Somalia's planning and interventions in Somalia.

The evaluation was conducted in phases. The first phase consisted of a review of documents supplied by UNICEF's Monitoring and Evaluation Officer to identify each agency with a role in the execution of joint programmes managed with UNICEF's support. Documents were also collected from the partner agencies. A list of documents reviewed is in Annex 1. From these documents, and in consultation with UNICEF, the following key elements were developed:

- A list of UNICEF's partners in order of funding; partners were grouped as International Non-Governmental Organisations (INGOs), National NGOs and Community Based Organisations. (Annex 2)
- A list of key persons and key organisations with which individual interviews were held (Annex 3);
- Interview guidelines for key informants;
- Data collection instruments for
 - Implementing Partner Organisations (Somali, UN and INGO);
 - UNICEF Zonal Offices
 - Health Facilities

The UNICEF Health and Nutrition Planning meeting held at the Landmark Hotel on 25 and 26th January was attended by the consultants. This forum was used to brief the participants, who were UNICEF staff from the field and headquarters, about the evaluation. At this meeting the consultants made the necessary arrangements for the field visit and drew up tentative field programs.

The team leader paid several visits to the Data Management Information Unit of UNDP to obtain relevant maps for the field visits, and database on the population of Somalia. .

Decisions on which districts and facilities would be visited was based on the following criteria:

- Security in the area – especially in the South and Central Zone;
- Accessibility – Two regions of Southern Somalia (Middle and Lower Juba) are partly inaccessible; Mogadishu remains closed for International staff members and the road from Beletweyne (Hiran Region) directly to Mogadishu also remains closed for UN vehicles.
- Routes along which several agencies could be met were given preference, and flight connections between the zones and between towns were given priority.
- The consultants ensured that the choice of areas to be visited included at least one partner from each of the three groups explained above (Annex 2).

Due to time constraints and issues of security, the choice of areas for the field visits was not a random selection. Neither was it based on population distribution or the extent of coverage. Therefore field findings are used to illustrate examples of planning, implementation, UNICEF-partner relationship and the relevance of UNICEF's Health and Nutrition Programme.

Based on the above criteria, the areas and agencies listed below were selected for the field visits. When possible community members were also interviewed.

South and Central Zone:

Baidoa (Bay Region):

UNICEF Somalia Office

International Medical Corps (IMC) Regional Office and IMC supported Adada MCH

Somali Red Crescent Society (SRC)- Regional Office and SRC supported Isha MCH

Degror Medical Organisation and its Maternal Child Health Centre (MCH)

World Vision Regional Office

Tuberculosis clinic run by World Vision and supported by World Health Organisation.

Huddur (Bakool Region):

IMC Regional Office and MCH,

Medecin Sans Frontiere (MSF)-Belgium

The Kala Azar Ward

Rhabdure (Bakool Region):

IMC supported MCH

Burhakaba (Bay Region):

World Vision supported MCH

Merka (Lower Shabelle Region):

COSV Regional Office and Shalembot MCH (supported by COSV)

Mobile immunisation teams

Several MCHs and health posts.

North East Zone:

Bossaso:

UNICEF Somalia Office

Gardo:

AAH Field Office, Programme Co-ordination Office, and two health facilities
Garoowe:
Ministry of Social Affairs (MOSA)-Directorate of Health,
Somali Red Crescent Society (SRCS)
Galkacyo:
Medecins sans Frontieres (MSF)-Holland Field Office
MCH Galkacyo

North West Zone:

Hargeisa:
Ministry of Health and Labour (MOH&L)
World Health Organization (WHO) Zonal Office
International Co-operation for Development (ICD)
Boroma
Co-operazione Internazionale (COOPI)

Health activities in the field were observed and assessed by visiting health facilities managed by international NGOs, local NGOs, the administration, activities of the mobile EPI teams and the Community Based Organisations. Questionnaires were administered in all the static health facilities and both group and one to one discussions were held with staff. The evaluation team was accompanied in the field by the UNICEF Project Officer, Health and Nutrition (H&N) and a translator in the SCZ.

After the field work, data from the questionnaires was analysed and reports of the findings were summarised for each zone. (Copies of the questionnaires are in Annex 4.) These zonal reports are available for use by UNICEF and USAID. A draft report was written and reviewed by UNICEF and comments and corrections were incorporated into this final report.

4 EVALUATION FINDINGS

Evaluation findings fall into four major categories: Policy and Coordination, Management and Organisational Issues at UNICEF Somalia, Health and Nutrition Activities and Results, and Addressing the Health and Nutrition Needs of Somali Children and Women in the Target Areas. Sections following the Findings include Lessons Learned and Recommendations and New Initiatives.

4.1 Policy and Co-ordination

The post-conflict environment in Somalia is a particularly difficult one in which to operate. Somalia is no longer a nation-state with international recognition. Zonal and district administrations are at different stages of development and have very limited funds and capacity to formulate and implement health policy, operational plans and programmes. While a great deal has been accomplished to address these issues, there is no central body with the mandate and legitimacy to formulate policy and co-ordinate the diverse range of stakeholders involved in the planning, management and delivery of health services. The consequences are: that progress is slow, decision-making is fragmented and a huge amount of time and resources must be allocated to building consensus and negotiating agreements

with many organisations (e.g. UN agencies, other international organisations, multilateral agencies, INGOs, local NGOs, Zonal and district authorities). In view of the security problems, the fragmented and weak Somalia institutional infrastructure, the diversity of donor and implementing agencies, and the difficulties of staff recruitment and retention, problems of coordination and management are inevitable. While much remains to be accomplished, it appears that substantial progress has been achieved and most stakeholders are committed to the resolution of the critical problems.

The Somalia Aid Co-ordinating Body (SACB), with the strong support and participation of UNICEF, USAID, the EEC, UNDOS, WHO and other international and Somali organisations has played a major role in promoting policy development, strategic planning, programme planning and co-ordination. The task is, however, extremely complex and subject to divergent interests, concerns and capacities of the various stakeholders. **Within this context it is very difficult to isolate and evaluate the contributions and effectiveness of each participant, including the role of UNICEF.**

UNICEF provides technical assistance, supplies and other resources to assist implementing agencies but does not deliver services nor does it have the authority or mandate to manage the programmes and projects of agencies that deliver services. In view of this and other constraints such as the lack of adequate baseline and monitoring data, it is impossible to determine the impact of programmes and attribute results proportionally to the diversity of actors involved in management and service delivery.

A general observation on the overall policy and programme objectives is that although they are now fairly well formulated (i.e., the Strategic Health Plan), they are far too ambitious in view of the limited funds and other available resources. What is needed is **a clear establishment of priorities linked to action plans formulated within the limits of available resources.**

4.2 Management and Organisational Issues at UNICEF Somalia

UNICEF has a well designed, decentralised management system with Zonal positions filled by medical professionals. It is, however, faced with the task of managing a diverse range of partners some of who perform well and others with more limited capacity.

Management and organisational issues at UNICEF/Somalia include the recruitment and deployment of staff, and the timeliness and accuracy of reporting from their implementing partners. Unfilled vacancies have caused problems for UNICEF, UNICEF's partners and USAID, and occasionally interfered with UNICEF's ability to implement, manage and monitor activities. An additional constraint to effective performance is the lack of effective dissemination of PHC and MCH management and PHC guidelines and standards in the field. While the Somalia Health Sector Co-ordination (SHSC) of the SACB has responsibility for producing many of the MCH and PHC guidelines, UNICEF does have guidelines (e.g. for Expanded Programme for Immunisation) and should ensure that they are distributed, understood and used by partners implementing the projects.

Another management issue is that while UNICEF is held responsible for many management and supervisory activities, it actually has limited to no authority over the NGOs and local authorities. This overall issue has been recognized and is under discussion.

4.2.1 Staffing Issues

UNICEF/Somalia has three types of contracts for fixed and temporary positions: Fixed Term (FT), Temporary Fixed Term (TFT) and Special Service Agreement (SSA). It has Nairobi and Zone-based health positions and employs a combination of international expatriate and Somali professional staff. In the section below, the positions filled by INTERNATIONAL STAFF are in CAPITAL LETTERS. Posts filled by Somali National Staff are written with Initial Letters Capitalized.

NAIROBI

- PROGRAMME OFFICER FOR HEALTH AND NUTRITION. The post is currently filled although it was vacant for one year as UNICEF conducted a search for a qualified person to assume this position. During the interim period, a former UNICEF staff was recruited on a consultant basis for a six month term.
- PROGRAMME OFFICER IMMUNIZATION. The post has been filled for two years.

SOUTHERN AND CENTRAL ZONE

- PROJECT OFFICER FOR HEALTH. The position is filled by a person whose SSA contract was recently renewed for a period of three months.
- PROJECT OFFICER FOR NUTRITION. The post is currently filled and except for a brief period during which the evaluation was conducted, the position had been held by a person on an SSA contract.
- Assistant Project Officer for Health and Nutrition. The position is held by a Somali physician on a TFT contract.

NORTH EAST ZONE

- PROJECT OFFICER FOR HEALTH. The position is held by a physician on a TFT contract.
- Assistant Project Officer for Health and Nutrition. The position is occupied by a Somali physician on a TFT contract.

NORTH WEST ZONE

- PROJECT OFFICER FOR HEALTH. The post is filled by a physician who is also the “Resident Programme Officer.”

- Assistant Project Officer for Health. The position is held by a Somali physician on a TFT contract.
- Assistant Project Officer for Nutrition. The position is held by a Somali on a TFT contract.

UNICEF also employs Somali nationals as support staff at Zonal offices.

UNICEF staff have the option of applying for another post after a period of two years in one duty station, and UNICEF has had problems in keeping all of the Somalia posts continuously filled. In general, Nairobi-based International staff remain in post for approximately three years and those in the field for about two years. While there have been some significant gaps due to difficulties in recruiting qualified professionals, UNICEF appears to have taken steps to address this through the use of experienced interim consultants.

From the perspective of some of the organisations contacted in this evaluation, inadequate human resources and lack of continuity have been UNICEF's main weaknesses. For them, the two to three years periods and temporary vacancies have led to logistical, management and reporting problems. Some partners expressed their concern over loss of guidance from UNICEF and the difficulties in establishing rapport with new staff.

The data provided on the occupancy of UNICEF positions indicate that while there were a few long vacancies in some posts, UNICEF has done fairly well in meeting its staffing obligations. For the past two to three years, the total number of health and nutrition position years¹ is approximately 28. The data indicate that UNICEF has filled the posts for almost 25 of the 28 person years (295 of 334 person months) which is 88 percent (88%) of the time. This figure includes positions filled by temporary staff but as the discussion above shows, the use of interim staff is not large in proportion to the total person months that the positions have been open.

There are differences in these results among the various work stations. Nairobi and the CSZ had key staff positions filled approximately 91 percent of the time (91%) during the past 36 months. For the NEZ, the figure is 82 percent (82%) of the time.

Staffing deficiencies cause programme problems in the field, and in Nairobi. UNICEF is sometimes criticised for not being able to supervise its partners adequately, and does not have sufficient managerial capacity to monitor all its partners and project agreements. Some INGOs and local administrations complain that UNICEF does not consult and plan with its partners in the field.

Staffing deficiencies also cause problems for donors. USAID states that reports are sometimes delayed, causing problems for their own reporting and monitoring requirements. Institutional memory is lost when positions go unfilled and there is often no overlap between those leaving and their replacements. Recently UNICEF filled the vacant positions, and positive steps have already been taken to resolve problems caused by the shortage of staff. Some of the management and coordination problems have been addressed. In the SACB UNICEF chairs, the Nutrition working group and is the vice chair for the Health Co-ordination Committee.

¹ Position years is calculated by multiplying each position by the number of years the position has existed and totaling for all positions.

4.2.2 PHC and MCH Management and PHC Guidelines and Standards

Although the evaluation team was instructed to review UNICEF Somalia PHC and MCH management and PHC guidelines and standards and to give recommendations on improvements or changes as necessary, **the team was unable to find copies of these guidelines and standards.** Two Zonal offices reported that they were around – somewhere – but that they had not been distributed to facilities. The guidelines and standards need to be distributed and put into practice at the health facilities and in outreach activities. They need to be monitored and evaluated in the field to see how effective they are and how they need to be adapted to field conditions and, if necessary, modified.

4.3 Health and Nutrition Activities and Results

Contracts with USAID support UNICEF's country programme, of which the main elements are

- strengthening the health service system;
- maintaining/increasing the current immunisation coverage;
- improving reproductive health services
- preventing outbreaks of infection;
- preventing and reducing malnutrition among women and children.

4.3.1 Strengthening the Health Service System

In the early and mid 1990s, UNICEF and other international agencies focused on rehabilitation and renovation of infrastructure. In the years under review for this evaluation (1995-2000), UNICEF moved from rehabilitation to service provision, and subsequently from direct provision of services to support of other agencies working in Somalia.

Recent UNICEF-USAID contracts state that UNICEF will strengthen the health service system with training and supervision, the provision of drugs and supplies, and the improvement of reporting for project monitoring. The trend is in the right direction, but much **more time is required to develop local capacity in management and service delivery.** In addition, the capacity of the implementing agencies to function as **development organisations** rather than just service providers requires more attention. In practice, this will require an investment in training NGO staff to strengthen their public health, medical, management and training skills.

UNICEF's strategy is to work in partnership with other UN agencies, local governments, international and local NGOs, and community-based organisations. In North West Somalia, UNICEF's major partner is the Ministry of Health and Labour of "Somaliland." In North East Somalia, it is the Ministry of Social Affairs of the State of Puntland. In the Southern and Central Zones, which are still often in a state of emergency, UNICEF works with international and local NGOs, community based organisations and local authorities.

Expectations, objectives and amounts of support of UNICEF and its partners are discussed and negotiated in the field and then formalised in project agreements. The project agreements are prepared in a standard format by the UNICEF Zonal Office and finalised in

Nairobi. Objectives are standard in all agreements and although targets are set (e.g. immunisation coverage 80%), target populations are not clearly identified. In the absence of accurate demographic and geographic data the current target populations are based on district population estimates which over-estimate the actual catchment population. Most objectives in the project agreements are medium and long-term, for which it is difficult to expect objectively verifiable indicators and reliable verification.

UNICEF supplied the evaluation team with copies of all of the project agreements for the current year (listed in Annex 2). There are 35 contracts for a total of \$1,943,045. All of the contracts have provisions for supplies, totalling \$1,628,611, or 84% of all project funds. Less than half the partners receive cash contributions; (\$314,434). INGOs receive 87 percent (87%) of all supplies and 94 percent (94%) of cash contributions. Only 13 percent (13%) of supplies and 6 percent (6%) of cash go to national NGOs, community-based organisations and local authorities. **This allocation pattern should be monitored and targets set for increased percentages to the Somali organisations.**

In the North West (“Somaliland”), UNICEF has supported the Health Sector Reform process since 1997. Support has included technical assistance to formulate and write:

National Health Strategic Plan
Health Sector Reform Policy, and
Master Plans for each region.

UNICEF’s programme focuses on enhancing the capacity of the administration to develop and support a sustainable health care system. Government commitment to health care is increasing. The health budget is now 3.6 percent of the total (up from 1%), and donor support is now 75 percent (down from 94%)

Seventy percent (70%) of the total budget of the health sector comes from UNICEF, which supports primary health care, EPI supplies and cold chain, nutrition, reproductive health, and FMG education. UNICEF supplies drugs to 45 MCHs and 125 health posts, and has provided approximately 250 TBA kits.

The “Somaliland” National Health Policy includes cost-sharing. UNICEF assisted the MOH&L to pilot cost-sharing projects, and cost-sharing has now been introduced into most of the MCHs in the zone.

By offering this support **UNICEF has empowered the MOH&L and its partners to be directly responsible for the delivery of health care.** The MOH&L is positive about the close collaboration with UNICEF, and UNICEF’s approach to assisting the health sector to develop.

INGO partners in the North West Zone include COOPI in Awdal Region and Norwegian Peoples Aid in Sool Region (Las Anod).

There has been substantial progress in the organisation and development of health services in the North West. This appears to be attributable to the combined efforts of the MOH&L, UNICEF, and other donors, INGO and local organisations. Most important is the public sector’s commitment to and investment in the health sector.

In the North East Zone, UNICEF's major partner is the Ministry of Social Affairs of the Puntland State of Somalia (MOSA). UNICEF has 31 sub-project agreements in the NE Zone for a total of \$238,126 in cash and supplies; 23 of these agreements (74%), and 56 percent of total funds are with the MOSA-Directorate of Health.

UNICEF and WHO staff and consultants assisted the MOSA to develop a Health Policy and Strategy Framework. **The document has not proven to be as useful as those developed in the North West Zone.** It is based on a disease-centred approach to planning, and does not address key causes of poor health status in the individual, the family and the community. Vision and Mission statements appear more as shopping lists than as health policy directions, and the health strategy framework does not benefit from nor build upon other documents on health policy and planning recently developed in the zone.

The relationship between UNICEF and MOSA is not as productive as that between UNICEF and the MOH&L in the NW. Zone. In part this is due to the relatively short time that the MOSA has been in existence. The extended time period in which UNICEF's position of Resident Project Officer and Project Officer for Health and Nutrition were unfilled contributed to the problems and hindered UNICEF's ability to develop an effective collaborative relationship to the MOSA. Complaints of the Director General of MOSA are that:

- UNICEF makes agreements with NGOs in Puntland without consulting the Directorate of Health and,
- UNICEF provides more support to the N.W. Zone (the MOH&L) than to MOSA, and to the Directorate of Education in Puntland than to the Directorate of Health.

Despite problems in the relationship, the Director General expressed appreciation to UNICEF for the provision of drugs and vaccines and as a catalyst in the health sector development process. The relationship is seen by both sides as improving.

NGO partners in the North East Region include Aktion Afrika Hilfe (AAH) and the Somali Red Crescent Society, (SRCS) with whom UNICEF has project agreements to provide vaccination supplies and cold chain equipment; and Médecins sans Frontières-Holland (MSF-H), with whom UNICEF has an agreement for support to KalaAzar intervention and for provision of delivery kits for TBAs. **All 3 agencies report good working relationships with UNICEF.** The NGOs are based in different regions and provide synergistic support to the delivery of health care: AAH supports the PHC programme in Bender-Beila, Gardo and Iskushuban; SRCS supports Mudug and Nugal regions and MSF-H supports the Galkacyo Hospital.

The difficulties in the North East Zone are not unexpected in view of the relatively short time the administrative system has been established and the staff vacancies at UNICEF. Most important is that the organisational difficulties between UNICEF and MOSA and INGOs have been identified and are being addressed. UNICEF's experience in the North West can be drawn upon to address the key issues and move forward in collaboration with MOSA.

UNICEF operates in 71 districts in the Central and Southern Zones. At any one time, activities are carried out in about 53 districts. The majority of health facilities are supported by international and national NGOs which are funded by external donors. There are a few isolated services offered by private individuals, although private “pharmacies” do play a significant role in the treatment of illness just as in the North West and North East zones. The quality of care offered by the private sector, however, remains questionable and requires attention. Specific measures are discussed in the section on “New Initiatives” at the end of this report.

UNICEF has established active partnerships (with signed agreements) with all the agencies working in the health sector in the SCZ. As a part of UNICEF’s strategy to reduce dependency on external aid, UNICEF has worked to identify and support community based organisations and local administration as partners. In the SCZ, 27 of UNICEF’s 47 partners are community based organisations.

ICRC is planning to move out of Hiran, Middle and Lower Juba because these are not areas of conflict anymore. They will hand over the facilities they are supporting to SRCS, and SRCS has in turn asked UNICEF for support. UNICEF has agreed to support these facilities on the condition that the out-patient department (OPD) will also offer MCH services. SRCS will have the responsibility of recruiting nurse/midwife and supplying OPD drugs. UNICEF will now support EPI programmes in Lower/Middle Juba, Lower/Middle Shabelle and Baidoa.

International NGOs have selected their areas of implementation independently, and unlike in the NE and NW, one can find more than two agencies in the same district, especially in the urban centres. Another variation in the SCZ is the prominence of a national NGO, SRCS, which supports a network of health facilities. In some districts, UNICEF also supports local health authorities. The choice of partnerships in the SCZ is based on availability rather than capacity and the commitment to the delivery of health services. In reality, UNICEF often has little choice in selecting the agencies it works with and must do its best with those in the field.

In the SCZ, implementing agencies have different views of UNICEF. SRCS sees UNICEF’s support as crucial in the management of health care delivery, and seeks UNICEF’s support for facilitating training. World Vision sees UNICEF as a complimenting partner in the implementation of their community based PHC programme. Other agencies interviewed (COSV, IMC and AMREF) feel that UNICEF has recently taken several unilateral decisions and that partners are not sufficiently involved in planning, although they are expected to implement what has been decided. This is a concern mainly in the area of NIDS, which is discussed later in this report.

4.3.1.1 Health Care Services

One of SACB’s responsibilities is to provide guidelines for a minimum package of MCH services, but these guidelines have not been finalised. However, services offered in the MCH centres are generally standardised in all the three zones of Somalia. The MCHs offer the following preventive, promotive and essential curative services:

- Ante natal care
- Post natal care
- Delivery care
- Immunisation of children and antenatal mothers
- Growth monitoring
- Health education
- Curative services for children attending the MCH
- Supply of essential drugs for MCH

Some MCHs also offer the following services:

- STD management
- Supplementary feeding programme(SFP)
- Laboratory services
- Family planning
- Adjoining outpatient curative services.

UNICEF focuses on primary level care but partner agencies often support complimenting services for example laboratory support by WHO. Laboratories were not targeted for this evaluation, but one was visited. Shalembot MCH(in SCZ) offers laboratory services to the patients at a cost. The laboratory technician claims that she was trained by WHO, but she had minimal knowledge of temperature controls for reagents. She offered a variety of tests, including an instant VDRL for diagnosis of syphilis. However, she didn't know that this test is carried out on blood serum. One of the most common examinations was a blood slide for malaria. While the patient must pay for the test, the chances for a false negative seem high at this lab. If the laboratory does not provide quality services, the patient might be better served by being treated symptomatically.

UNICEF is committed to providing preventive, promotive and ONLY essential curative services. However, on examining the child register in all the facilities that were visited, it was clear that over 95 percent of the children were only brought to the clinic because they were sick. The only exception to this was Sheikh Nur MCH in Hargeisa (NW) where only a small proportion of children (about 10%) went home with treatment. This pattern of clinic attendance poses a very specific question about the concept of preventive health – does the community differentiate between preventive and curative services and the benefits of preventive care? Bringing a child to the clinic for immunisation and growth monitoring is equated to being treated and getting drugs.

4.3.1.2 Training & Supervision

Basic health services are delivered by the available health personnel in the area. While there are individuals who were trained at the University in Mogadishu and other institutions of learning before the war, **the majority of staff (termed “auxiliary”) in the health services do not have any official certification and their technical and professional qualifications are based on “self reported competence.”**

In the last six years, UNICEF has become the major provider of training and has embarked on providing refresher-training courses in several fields to update the skills of the health workers. Some of the refresher courses held were:

- Nutrition and Family Planning
- Cholera, malaria, polio
- Female genital mutilation(FGM)
- Sexually Transmitted Infections (STIs)
- EPI and the cold chain
- Rational use of essential drugs
- Integrated Management of childhood illnesses

Auxiliary staffs are also beneficiaries of short term training specifically for the tasks they perform. For example, all the auxiliary staff who manage the cold chain have received training in EPI and cold chain.

Partner agencies share the responsibility of training. The SRCs conduct a training programme for First Aid, and participants receive practical experience in the health facilities. Those trained in First Aid are often recruited as auxiliary nurses. Training in FP and FGM has been supported by UNFPA.

Uncoordinated training organised by different agencies has led to a “shortage” of staff in the health facilities in some areas. Over the years, the objective for attending workshops/seminars changed from learning to “remuneration by per diems.” Many of the agencies commented that there is minimal impact of training in the delivery of services as those who continually attend refresher training courses have little time in the facilities. However, **the evaluation findings in the field did not support this view.** While a few facility personnel had attended several courses, most had been to one or none in the past five years.

Last year a decision was taken at the SACB that all agencies should submit their training schedules to avoid duplication and repetitive attendance of some staff. In the NW zone, a list of participants has to be submitted to UNICEF/WHO before any training is held. UNICEF also has a list of staff for each facility and what training each one of them has participated in. It is hoped that with this kind of system, the problem of “Professional Workshop Participants” where a maximum amount of time is spent by health workers in workshops will be solved.

While this is a useful improvement, it is not consistent with the suggested emphasis on administrative capacity-building and decentralization. **In the future, at least in the NW and NE zones, training should be planned and coordinated through the Zonal authorities.** This means that UNICEF, other international agencies and the INGOS, should collaborate and help these authorities to develop and schedule their own training and continuing education programs.

Supervision remains a big constraint in the delivery of quality services. There is very little evidence that staff are supervised on the tasks they perform nor that there is systematic follow up after training. UNICEF’s training schedules do not have a component for follow-up or on-the-job supervision, nor does it have the capacity to do this task. The evaluation team found only one NGO (WV in Burhakaba) which assessed staff on a regular basis and planned training based on the weaknesses identified during supervision.

UNICEF's policy is to "continue providing technical backstopping to the various partners and strengthen monitoring through its field presence with its International and national staff, in all the zones." In reality, **UNICEF does not have the human resources to complete this task adequately.** (See UNICEF Staffing Issues). Although partner agreements with UNICEF allow health facilities to be visited and supervised by UNICEF independently, partners prefer transparent, joint visits so that shortcomings are discussed in the presence of health workers. With UNICEF's limited capacity to supervise, it depends largely on the information provided by its partners about their activities.

Until recently, UNICEF did not have any system of regularly monitoring the performance of its partners nor a system of carrying out an annual assessment of its partners. The Annual Review meeting where an annual assessment is carried out will address this issue in this and future years.. In the coming years with the declining number of international NGOs especially in the SCZ, and the increase in newly formed national and community-based organisations, **the needs for monitoring support will be increased.** These emerging young national organisations will require additional support through supervisory visits since their staff do not have the experience and professional training to operate independently and effectively..

In the NW, UNICEF strives to build the capacity of the MOH&L through providing logistic support for supervision on a monthly basis. Supervision is carried out jointly by personnel from MOH&L and UNICEF. In the SCZ, partners (especially the international NGOs) implement their activities independently, with minimal guidance and supervision from UNICEF.

There seem to be neither standards nor guidelines available in the field to direct the supervision process. UNICEF Somalia developed MCH and PHC Management Guidelines and PHC Standards. The evaluation team requested copies of the guidelines in every office visited, but only two offices were able to retrieve them. The NW Zonal office and the SRCE office in Baidoa had copies of the MCH guidelines.

In the NW Zone, the UNICEF office has developed a set of instruments for supervision. These were circulated to partners for comments, but no feedback had been received at the time of the field visits. An assessment of the instruments shows the following that **the instruments are very detailed and may not serve the purpose of a rapid and effective supervision visit.**

- Instrument 1 is based on the objectives and targets for the period under review;
- Instruments 2 and 3 probe into reasons for weaknesses in service delivery;
- Instrument 4 and 5 analyse time usage for various tasks; and
- Instruments 6 to 10 address services and management issues.

In the absence of standardised formats for training and supervision for Somalia, several NGOs have developed their own instruments. However, supervision by International NGO partners is often hampered by a high turn over of staff.

There was no evidence of supervisory reports at any of the agencies visited. Neither was there any evidence that a technical supervision was carried out in which the quality of service was assessed. **Health facility staff very rarely received feedback from supervision.**

While supervision in government and NGO facilities is still generally weak, it is still non-existent in the private sector. Only the MOH&L in the NW Zone attempts to regulate this sector. UNICEF recently supported the MOH&L to develop guidelines for doctors and pharmacies but they have not yet been enforced. Support has also been provided to the Health and Medical Council to develop a Health Act for approval of the administration. The guiding principles of this Act will streamline the issue of registration of the private practitioners and will allow the MOH&L to vet who is being licensed.

The development of effective service delivery and management in the three zones appears to be directly related to the capacity (or lack thereof) of the authorities in each zone. **This is consistent with models for post-conflict development. A major implication is for donors to continue capacity building activities.**

4.3.1.3 Local participation and cost sharing arrangements

UNICEF continues to advance in the development of local partners. In the NE and NW the local administrations are the major partners. In districts where local authorities are functional, UNICEF has identified local councils as partners. In the SCZ, local authorities of Wajid and Bardera district health boards have partner agreements with UNICEF. In Sool Region (in the NW), UNICEF has contracted a community-based organisation, Steadfast Voluntary Organisation (SVO) to provide logistic support for the transportation and distribution of supplies. Functions of SVO have now expanded to include garbage collection and campaigns for environmental sanitation.

In the NW Zone, UNICEF assisted the MOH&L to pilot a project in cost sharing in Gabiley in 1998. At the same time, one of UNICEF's partners (COOPI) initiated a similar project. The projects were evaluated and lessons learned from both approaches were applied to pilot projects in Borama and Berbera.

Currently, UNICEF, the MOH&L and the municipality are collaborating with the NGO International Co-operation for Development (ICD) in a cost-sharing pilot project in Sheikh Noor (outside of Hargeisa.). ICD contributes materials and supervision, as well as long-term experience in Yemen, to this cost-sharing pilot project. Here, the municipality of Sheikh Nur has taken the responsibility of remuneration of the health staff. With the management skills training provided by ICD to the health workers at this facility, one can see the systematic flow of patients, the improved quality of service delivery and the organised patient and drug records.

Cost sharing has now been introduced in most of the MCHs, health posts and hospitals in the NW and NE. Decisions on the use of the funds are made locally, and there are no general guidelines. Neither are there any basic management guidelines for cost sharing revenue and expenditure. For example, in Sheikh Nur, all the funds collected are put away for drugs. The municipality pays good salaries and does not use cost-sharing revenues for staff incentives. In Gabiley, when UNICEF first started cost-sharing, 70 percent went to staff

incentives, and the programme didn't work. The implementation was modified and now only 30 percent goes towards staff incentives. In Shalembot, NOBODY could explain where the collected fund went. Currently only a small proportion of total costs are recovered, but the percentage is higher for drugs. In some facilities, cost sharing now recovers \$350 for a \$750 drug kit.

Although there has been no systematic introduction of cost sharing in SCZ, some NGOs have introduced user fees for services offered. Community involvement is a major element of all of these programs.

There is clear but limited progress in the expansion of community participation and cost-sharing. The emphasis on cost recovery for drugs in the North West and North East has made substantial progress and there is now a firm basis for consolidation and expansion of cost-sharing activities.

One major shortcoming in the comprehensive expansion of cost recovery is the failure to utilise and follow-up on the recommendations in the report on health financing (DSA 1997) and in the Strategic Plan for the Health Sector in Somalia (SACB 2000). A plan for follow up activities was developed in 1998 but has not been systematically implemented.

In view of the low level of external funding and the strong need to establish a sustainable basis for the expansion of health services, all partners need to collaborate in addressing the technical, managerial and training issues related to health financing. The failure to do so during the past four years underscores the weaknesses in the organisation and decision-making process within the donor community. In short, an analysis was done and accepted and follow-up activities defined the specific interventions required, but little action has been taken. The result, a variety of pilot programs, but no coherent clearly defined system of policy, management, training and reporting for health care financing.

4.3.1.4 Logistical Support: Transport, Equipment and Supplies

UNICEF has been the lead agency in the provision of supplies for health services. Basic health kits are provided to health facilities starting new services. This kit includes essential furniture and equipment.

At every zonal office, UNICEF has a fleet of running vehicles (four-wheel drives) either purchased by UNICEF (as in NW and NE) or “permanently” hired (as in SCZ). UNICEF also has the financial capacity to hire additional transport when the need arises. UNICEF supports the distribution of essential drugs, vaccines and other supplies either directly to facilities or to partners for distribution depending on the agreement. In the field logistic support is pooled between UNICEF and its partners so that distribution of supplies and supervision are often carried out as joint activities.

An example is the distribution of vaccines and drug kits. In the NW Zone, UNICEF sends the supplies to the Central Medical Stores from where the MOH&L take over the responsibility to distribute them. In some regions warehouses belong to partners. UNICEF will transport the supplies to the regional destination and depending on the agreement, the partners will distribute supplies to the health facilities. In Awdal region, COOPI manages the warehouse

and takes the responsibility to distribute supplies. In Sool region UNICEF has contracted a community-based organisation, Steadfast Voluntary Organisation (SVO) to provide logistic support for the transportation and distribution of supplies. Functions of SVO have now expanded to include garbage collection and campaigns for environmental sanitation.

Of concern is the transport arrangement by UNICEF for NIDs, especially in the SCZ. Until last year, transport was usually hired in the different areas from the residents of the community. This encouraged community support, and provided income generation, and communities perceived and accepted immunisation as a beneficial activity. However in Merka, with the strong clan factions, there were mixed to negative responses to the NIDs, especially where UNICEF had made arrangements for transport directly from Mogadishu. Although UNICEF and WHO (joint partners for NIDs) may have had justifiable reasons for this arrangement, the communities and the partners stated that they were not informed of them.

Maintenance of equipment is a problem which can lead to the cessation of services. For example, in the Central MCH in Hargeisa, GM had not been carried out for 4 months because the weighing scale was broken. At the DMO clinic in Baidoa, patients suspected of suffering from high blood pressure were sent to a nearby private pharmacy to measure their pressure. These problems are not UNICEF's responsibility. UNICEF takes responsibility for maintenance of EPI cold chain equipment, and partners are expected to maintain other equipment provided by UNICEF. UNICEF will, however, replace non functioning or broken equipment if requested. **It is important for UNICEF to reinforce these shared responsibilities during meetings with partners and visits to clinics.**

4.3.1.5 Provision of Essential Drugs

UNICEF is the main supplier of essential drugs and expendables to the providers of health services in Somalia. UNICEF drug kits are received pre-packed and sealed from Copenhagen. A packing list with the expiry dates of each drug is included in the box for verification of the contents. The drug kit is designed to provide a 2 month supply of essential drugs for a facility caring for 2,000 patients (approximately 150 patients per week). UNICEF and its partners share the responsibility of distribution of the kits.

There is a world-wide problem with delivery of supplies on time. Drug kits are ordered nine months in advance. Orders are sent to the supplies division where drugs are purchased. If one item on the order is not available, the whole order gets held up. Packing is done only after all the items have been received. From order to delivery to Mombasa usually takes six months. **The system assures quality, competitive prices and good packing.**

One problem with this system is the lengthy procedure in ordering. Another problem is that the pre-packaged kits eliminate the possibility of individualising drug kits for facilities with seasonal and regional variations in disease patterns. A third problem is that the kits do not contain liquid medicines, thereby making it more difficult to treat small children.

An even greater problem is that the different drugs in a kit have different expiry dates. Most kits are sealed until they reach the health facility. Expired drugs and those with short

expiry dates will not be discovered until they reach the facility. Partners are requested to return expired drugs so that the bulk of expired drugs are found in the UNICEF warehouses.

At one time, the North East Region had a serious problem with the expired drugs. As they were sent back from the facilities, expired drugs steadily accumulated in the Bosasso warehouse, and some were even accidentally sent back out to the facilities. This damaged UNICEF's relations with the Director General of Health of MOSA, and with recipient facilities. To the credit of the UNICEF Zonal Office, , these problems have been vigorously and openly addressed in 2000, and the situation has significantly improved. The delivery of drug kits is now more timely. The team had to spend considerable time on remedying the situation, including removing the expired drugs from the kits and replacing them with new drugs whenever available.

During this evaluation, all facilities visited had drug kits that had been delivered within the prior two months. None of the medicines in the kits were expired.

Although the essential drug kit system has problems, it is probably most appropriate way of distributing drugs to facilities in Somalia at this time. Because data on morbidity and utilisation are poor, and facility management skills are weak, more individualised ordering of drugs would probably not be any more efficient.

4.3.1.6 Health Management Information System

Over the past four years, UNICEF has supported efforts by the SACB Health Sector Committee and WHO in the development of a Health Information System for all of Somalia. Much of the delay in the development of the HMIS was the SACB's concern that it be accepted and approved by all of its members. Because the turnover of personnel in most NGOs is so great (often only 3 or 9 months tenure), many new people and opinions were constantly available to question and modify the development of the HMIS at each step. The HMIS was always going "back to the drawing boards." That an HMIS is finally being implemented is a great credit to the persistence and determination of individuals in the agencies responsible. It will, however, be necessary to establish controls to ensure that as new expatriate and local staff are employed by the donor and implementing agencies, that they are adequately trained to use the HMIS. **Field level reporting forms have been developed, field-tested and approved.** The HMIS consists of the following elements:

- The Mothers' Register kept in the health facilities
- The Under-fives Register also kept in the health facilities
- A set of three monthly forms which are prepared by the health facilities:
 - Epidemiological Report
 - Reporting form for growth monitoring in MCH centre, and
 - EPI Monthly Report

Despite the great efforts made towards consensus and approval of the HMIS, there are still partner agencies that continue using their own reporting formats. These partners state that their own funding agencies require information that is not included in the HMIS. In these cases, the facility staff is required to fill out two sets of reporting forms or NGO district level personnel partners extract data from NGO specific forms completed at the facilities to

complete the HIS forms. For these reasons, **standardisation of reporting is still a long way off, and the accuracy of the data currently reported is questionable.**

An even greater problem was that many partners chose not to report at all. To remedy this problem, UNICEF tied distribution of drug kits to the completion of monthly reports, and this dramatically improved the returns, so that up to 75 percent of the agencies now provide monthly reports.. However, UNICEF is often pressured through the SACB to release drugs without production of reports, and this makes it difficult to fully implement the policy.

These forms are delivered to the Zonal UNICEF Office for data entry into the computer using HMIS software. A diskette (together with a hard copy) are then sent to the UNICEF Somalia Office, Nairobi (attention Project Monitoring and Evaluation Officer). In addition, the H&N team prepare several monthly, quarterly and annual summary reports, including “EPI figures” and “Epidemiology Report Summary.”

The HMIS could be used to identify emergencies, trends in diseases, EPI coverage, and partner performance, but the software was not designed for these functions. For example, the software does not allow aggregation of the data at different levels (i.e. zonal, regional, and district levels). In addition, the software is designed to give an update only on an **annual** basis.

the evaluation team did not find evidence that the information collected for the HMIS is used at any level. There is no feedback of information to the facilities, partners or zonal offices. This is a serious shortcoming of the HMIS. If it is not used nor seen as useful by the people who collect it, little effort will be expended to insure that it is accurate

4.3.2 Maintaining/Increasing the Current Immunisation Coverage

The annual reports (1999,2000) and the Master Plans of Action (1999-2000 and 2001-2003), reflect immunisation as UNICEF’s main concern in the provision of MCH services. Although the annual reports of 1998 and 1999 do not describe achievements in relation to set targets, the Master Plan of Operation for 1999-2000 and contracts between UNICEF and USAID sets targets to increase immunisation coverage of children under 1 year and tetanus toxoid coverage of pregnant mothers to 80 percent.² The same targets were carried forward for the year 2001-2003. UNICEF also plans to continue to contribute towards global eradication of poliomyelitis through national and sub-national immunisation days (NIDs).

UNICEF supplies vaccines, cold chain equipment and training to all partners in Somalia. Vaccines are ordered directly from the manufacturers and are often available within one week of placing the order. At any time, vaccines stores have at least six months of stock available. Reorders are based on utilisation in each health facility.

UNICEF is currently seeking mechanisms for expanding immunisation services through partnerships with the private sector . In the SCZ, UNICEF has agreements for provision of vaccines with a private practitioner, and in the NE with midwives. In the NW, the MOH&L has just submitted the Health Act for approval by the administration. UNICEF’s support to

² The current contract with USAID, 1 June 2000 to 31 May 2001 for Southern and Central Somalia and emergency areas in the North East proposes a coverage rate of 67%.

the MOH&L in applying the Health Act could be used as a vehicle for selection of private practitioners as partners in the expansion of EPI and other preventive services.

4.3.2.1 Cold Chain

In the North West Zone, there is a central store in Hargeisa, and every region has a cold chain store with generator support. The MOH&L supplies the regional stores and its partners with vaccines. Regional stores have their own inventories, and staff at the stores have been trained by UNICEF in the maintenance of equipment. They supply repair services at the district level as well as at the regional level.

UNICEF has set up a similar system for the North East Zone. Currently there is a central store at the Zonal office in Bosasso, and similar stores in Mudug Region (Garoowe Town) and Nugal Region (Galkacyo Town). A project agreement has been signed between UNICEF and AAH for a centralised cold chain for the districts of Gardo, Bender Beila and Iskushuban, but there has been a delay in the delivery of a generator.

The Southern and Central Zones have five warehouses in Mogadishu, Kismayo, Jowhar, Berdera and Baidoa. The cold chain at the warehouse level is well maintained with generators and refrigerators, but stores at the district level and the periphery experience problems. In the SCZ, a focal point has been appointed in the UNICEF Baidoa office, where all agencies are supposed to report faulty equipment, especially the cold chain equipment. However this system is weak and action is not taken promptly.

UNICEF is not able to monitor the cold chain at the field level, and delegates this responsibility to its partners. Several examples of improper maintenance of the cold chain discovered during this evaluation illustrate the need to devise ways of ensuring that vaccines are potent at the time of administration.

- At Shalembot MCH in Merka, vaccines are collected weekly in a cold box. The thermometer is not visible, there is no temperature chart to show that temperatures are taken, and the ice packs were melted although the facility planned to use the vaccines for another 3 days.
- At the central MCH in Hargeisa (NW zone), the thermometer on the refrigerator where vaccines were stored, was not working; the staff “assumed” that the temperature was within acceptable limits.
- At the MCH in Galkacyo, the ice liner does not appear to be working properly and the generator was not properly installed. The staff report that UNICEF has been informed of both problems many times, but no action has been taken.
- At Adada MCH and Degror Medical Organisation, vaccines are transported with ice packs from UNICEF on a weekly basis. The cold boxes do not have thermometers, and staff assume that as long as the ice packs are frozen, vaccines are at optimal temperature.

- But to end on a more positive note, at the Rhabdure MCH, the refrigerator is broken, but the facility has a stand-by car which collect vaccines from Huddur on a weekly basis. The thermometer on the cold box is working and a temperature chart was plotted with temperature reading twice a day.

4.3.2.2 Immunisations

Immunisation services are provided mainly from static facilities. However, there are mobile facilities in all zones, with the greatest number in the SCZ. UNICEF supports 43 mobile teams in the SCZ zone alone. Mobile EPI services are organised in all the zones during NIDs.

Every MCH is equipped with UNICEF support, to provide immunisation services. The policy for EPI is to immunise at first contact, which means that EPI services should be offered on a daily basis. However this is not always the case especially in the SCZ. EPI services are offered daily, three times weekly or on alternate days, depending on the choice of the nurse in charge. No criteria could be identified for the choice of the number of days for EPI.

Supplies of vaccines and expendables were found to be adequate in almost all of the facilities visited. Problems in supply at a few facilities were secondary to not having ordered enough.

Reports prepared by UNICEF do not refer to targets set in the Annual Plans, making it difficult to assess achievements. For example, the annual reports of UNICEF Somalia of 1998 and 1999 do not compare achievements year by year. The 1998 Annual Report has tabulated the immunisation coverage during the NIDs in relation to population estimates, routine coverage and coverage reported by local surveys. The 1999 Annual Report presents absolute numbers for routine immunisation and percentage coverage during NIDs, without the reference population.

Although the goal of 80 percent has not been reached, the end decade Multiple Indicator Cluster Survey (MICS) shows high immunisation coverage in the SCZ. In the North East, however, immunisation rates for every vaccine but polio have fallen.

- BCG: About 69% of children under one year had been vaccinated against BCG, the highest coverage being in the SCZ (90%) and the lowest in the NE (41%).
- DPT: The percentage coverage for DPT declines with increasing doses, from 57% to 33%. The SCZ had the highest coverage for DPT1 (84.2%) and the lowest coverage was in the NW for DPT3 at 10%.³
- Measles: Only 37.5% of children had received measles vaccine prior to their first birthday. Again the SCZ had the highest coverage with 60%, and the North East had the lowest with only 17.6%. Nomadic children had the highest percentage of measles

³ In the NW zone, which has the highest number of health facilities in relation to its population and access has not been considered a major constraint to the utilization of health services, alternative explanations are necessary for this low coverage.

vaccination (50%), but the total number of nomadic children in the survey was very small (84).

- In the NE Zone, coverage was much higher in 1998, particularly for measles. Between the 1998 and 2000 MICS, measles vaccination fell from 40% to 17.6%, DPT3 from 27% to 18.8%, BCG from 49% to 41%. Polio coverage rose from 27% to 31.3%.

The MICS carried out in the NE in 1998 show that, over 70 percent of the nomadic children who attend the outreach clinic days children receive vaccinations on that day. The mobile clinics play a crucial role in the provision of immunisation services and the end decade MICS shows the highest coverage for all the antigens in the SCZ where UNICEF supports the highest number of mobile teams.⁴

Another concern is the difference in immunisation practices. A few clinics offered immunisation services to children on a daily basis, not missing any opportunity to immunise at the expense of vaccine wastage. Isha MCH in Baidoa claimed that they had been requested to vaccinate only on alternate days to avoid vaccine wastage. This MCH has no way of verifying if the mothers who had been asked to return, actually come back and therefore raises the issue of missed opportunities.

A field vaccinator was found to be swabbing the thigh of a child only after vaccinating. Discussions with the EPI supervisor revealed several schools of thought – to swab or not to swab, what to use for swabbing the skin, the purpose of swabbing the skin after immunising and many more. No written guidelines were available to clarify this issue and it appears that there may not be any written guidelines worldwide.

Despite improvements in the EPI services and the inputs in terms of equipment, supplies, training and logistic support by UNICEF, the EPI services still have many short -comings:

- Over estimation of the population at the National level (estimates from DHIU are one third of the national estimates), leading to a wrong denominator for assessing immunisation coverage.
- Inadequate mobilisation and sensitisation of the community for EPI. At a village where an EPI team was carrying out its immunisation activities, residents of the household next door were not aware that the team was there. At another household the mother refused to bring her children for immunisation, as her husband had not given her consent following the consequences of the previous immunisation (child ran fever for two days).
- The potency of the vaccines, especially those that are returned to the stores after a week, from the MCHs without refrigerators, and the high percentage of facilities (visited by the evaluation team) with cold chain problems.
- Missed opportunities when EPI services are not offered daily.

⁴ The report cautions that the sample size is small and this may not be statistically significant.

- Authenticity of EPI coverage data, especially from the mobile clinics. UNICEF depends solely on its partners to immunise and report on the coverage and does not have the capacity to verify the data.

Poor stock records at the stores – it is not possible to estimate the amount of vaccine in stock by lots. A strict monitoring plan for inventories and supplies has been established but due to inadequate staff, this plan is not adhered to in the North West and South Central Zone.

4.3.2.3 National Immunisation Days for the Eradication of Polio (NIDs)

The global programme for the eradication of polio needs special mention. Last year, NIDs overshadowed all other health related activities to the extent that in some areas, services came to a halt when a NID round was being conducted.

Per diem rates paid by UNICEF are far higher than what other agencies pay, hence it becomes difficult for the NGOs to sustain their staff. Many NGOs felt that they were losing staff they had invested in to NIDs.

In the SCZ, there was discontent among the health workers who had been offering voluntary services (in the COSV supported facilities) when others were recruited and remunerated for NIDs. The COSV Health Co-ordinator felt that they would not be able to carry on with the routine EPI activities because of the issue of remuneration. This issue was still under discussion at the time of the evaluation.

In the NW zone, WHO set up an organisational structure so that district assistants recruited personnel for NIDs. WHO stated that the first choice for recruitment of staff for NIDs are health workers, and the community health workers (TBAs, CHWs) complained bitterly that people from other districts had been recruited to work in their area. This has “killed” the morale of the TBAs and CHWs who have, otherwise, been offering their services on a voluntary basis and see the NIDs as an opportunity to be rewarded with remuneration.

During NIDs, UNICEF provides the necessary logistic support but finds it difficult to supervise the mobile teams. Partner agencies are expected to supervise teams in the areas they work in. And yet, in Luuq District, AMREF reported that despite being a major partner and implementing agency of UNICEF in the Health and Nutrition Programme, NIDS had been planned without their involvement.

In the Merka, NGOs usually hire transport from local residents. For NIDS, UNICEF hired transport from Mogadishu. No explanation for this was given to UNICEF’s partners who had to live with angry feelings from the strong clan factions and therefore a negative response to NIDS.

Questions have been asked about the authenticity of the data, for coverage and vaccine usage. There is no analysed data from the field to show coverage vis a vis the target population. Analysed data is now available at the UNICEF Somalia Nairobi office

A notable achievement which, can be credited to NIDs is the unusually high immunisation coverage in the SCZ. EPI outreach activities have also contributed to

general health activities by combining distribution of Vitamin A, ORT and Iron/folic supplements with EPI activities.

4.3.3 Improving Reproductive Health Services

Sexually Transmitted Disease management and Family Planning services were introduced in selected clinics under a UNFPA supported Reproductive Health programme, but this programme ended in December 1999. UNICEF's project objectives for the year 2000 included a component for reproductive health services. Specific objectives addressed:

- access to and use of professional midwifery and emergency obstetric care,
- access to reproductive health services (FP and STDs),
- immunisation and use of iron and folic acid in at least 80 percent of pregnant mothers, and
- increase in the number of qualified midwives.

UNICEF's basic health centre kit provides equipment required for emergency deliveries. Although MCHs do not have in-patient facilities for conducting regular deliveries, all the MCHs reported conducting emergency deliveries at least once or twice a month.

A KAP survey carried out in the NW in 1998 reported that mothers often do not see the need to attend ante-natal clinic if they are in good health. Only 34 percent of the mothers had received ante-natal care in their last pregnancy and there was tendency to present to the clinic only after the second trimester. Urban mothers tended to use the services of an MCH but only five percent of mothers from the nomadic population had received any formal ante-natal care. Discussions with the midwives during the evaluation field visits revealed that trends of ante natal attendance noted in the survey remained unchanged.

Family Planning services collapsed completely after cessation of the UNFPA programme. In some urban centers like Boroma in NW, clients who choose to continue using oral contraceptives purchase pills from private pharmacies and bring them to the clinic for instructions. However, lactational amenorrhea is the most frequently used method for family planning.

4.3.4 Preventing Outbreaks of Infection

Preventing outbreaks of infection is an objective of the current contract with USAID (1 June 2000 to 31 May 2001), but not of the previous contracts. While it is therefore inappropriate to evaluate UNICEF's performance on a new objective mid-way through a short-term contract, UNICEF has performed well in this area in the past, and it is an important UNICEF mandate which should continue.

In emergency situations caused by outbreaks of cholera and malaria, UNICEF has shown the capacity to mobilise supplies within 48 hours. UNICEF has recognised the endemicity and periodicity of malaria and cholera and has appropriately planned stockpiles of needed materials and protocols to combat these and other emergencies. A recent example was the

outbreak of fire in Jowhar, Berdera and Kismayo. UNICEF prepared an inventory, mobilised staff and rehabilitation kits were ready for distribution in two days.

UNICEF should be encouraged to maintain this preparedness and institutional capacity, which has been an extremely important function of UNICEF during this decade. In the future, the implementing agencies, particularly the health authorities in each zone need to be trained in surveillance techniques and in how to respond to disease outbreaks.

4.3.5 Preventing and Reducing Malnutrition among Women & Children.

The main objective of UNICEF's nutrition programme is "to increase child caring and feeding practices with a view to addressing the underlying causes of malnutrition." UNICEF's strategies to accomplish this objective are to:

- Contribute to the zonal/regional nutrition strategy development for local administration;
- Strengthen growth monitoring and nutritional surveillance and ensure linkage with planning implementation of interventions to reduce malnutrition;
- Promote positive feeding habits and hygiene practices, focusing on promotion of breastfeeding and good weaning practices
- Ensure stronger linkages with other sectoral programmes, notably health and water and sanitation programmes;
- Provide Vitamin A capsules to at least 60 percent% of the children aged 6 months to 5 years living in settled areas (>250 inhabitants);
- Ensure that at least 60 percent of pregnant women receive iron and folic acid supplements in settled areas.

4.3.5.1 Nutritional Survey Data

Levels of malnutrition in Somalia have seasonal variations, on top of which differences exist among and within zones and among different populations (i.e. displaced, nomadic, settled, town, rural, etc.). Methodology of the surveys also varies. These variations make comparison of data from different surveys difficult. The diversity of indicators used for growth monitoring also makes it difficult to compare nutrition data. In the NE and SCZ, weight for height and the Z score are used, but clinics in the SCZ supported by IMC use weight for age. In the NW, weight for age is used as the common indicator for malnutrition, and weight for height is only used for surveys. Data from different nutrition surveys report dramatically different results, and it is difficult to understand the causes of these differences. For example:

- In the SCZ, UNICEF supported nutritional surveys in different towns between August 1999 and February 2000. Results estimate a global malnutrition rate of 25 percent and severe malnutrition at 4.5 percent(weight for height and using the Z score).

- A UNICEF survey in Huddar town in September 1999 reports a global malnutrition rate of 22.7 percent, and a severe malnutrition rate of 4 percent. Ten months later (July 2000) IMC conducted a survey in Huddur and reported a global malnutrition rate of 12.6 percent and 2.5 percent of children with severe malnutrition.
- A UNICEF survey in Rhabdure town (Bakool region) in February 2000 reported global malnutrition at 30 percent and severe malnutrition at 4 percent. An IMC survey in El-Berde and Rhabdure districts conducted 6 months later (August 2000) reported a rate of 13.7 percent for global malnutrition and 1.4 percent for severe malnutrition.

The table below compares these data sets.

Table: Comparison of Malnutrition Rates from Different Surveys

Location	Date(s)	Global Malnutrition	Severe Wasting
SCZ towns	Aug 1999 – Feb 2000	25%	4.5%
Huddar town	September 1999	22.7%	4%
Huddar district	July 2000	12.6%	2.5%
Rhabdure town	February 2000	30%	4%
Rhabdure district	August 2000	13.7%	1.4%

Viewing this data together, it is difficult to understand trends or seasonal patterns. How much of the difference may be due to differences in methodology or training of data collectors is also hard to determine. It is also difficult to compare the two IMC surveys as age stratification and groupings are different in the two surveys. The sampling and methodology are similar between the UNICEF and IMC surveys, but there were differences in the sampled populations (towns for the UNICEF surveys and districts for the IMC surveys).

The end decade MICS reports an overall global malnutrition rate of 17.2 percent for Somalia and the highest prevalence of malnutrition in the SCZ (27 percent with moderate malnutrition and 9.5 percent severe malnutrition by weight for age, 21.2 percent and 4.6 percent moderate and severe malnutrition by weight for height). This is despite the supplementary food distribution programme in the SCZ.

A comparison of malnutrition rates over time in the North West and North East Zones reveals an increase in malnutrition over the past 5 years.

Table: Changes in Malnutrition Rates over Time in Northern Somalia

Date of MICS	North West Zone	North East Zone
MICS 1996	8%	
MICS 1998		12%
MICS 2000	10%	14.2%

4.3.5.2 Growth Monitoring (GM)

UNICEF has supplied all MCHs with equipment for growth monitoring, on the assurance that partners will be responsible for the use and maintenance of the equipment. However,

UNICEF but has not been able to monitor the functioning of the equipment... Several facilities visited during the evaluation had broken scales.

The Z score card sheet starts with a height of 58 cm. Infants below this height are not weighed at all as it is assumed that malnutrition does not exist below the age of six months. An assumption like this tends to disregard infants who are weaned at a very early age and those who stopped breastfeeding before 4 months. This particularly impacts on data from North East Zone, where only 1 percent of infants are exclusively breast fed for 4 months, and North West Zone where bottle feeding at all ages is widespread.

Despite UNICEF's continuous investment in nutrition and GM training, it appears **that health workers still have difficulties in routine GM**. For example, a child was observed being weighed at Shalembot MCH. The height was measured and the child was labelled "good". The consultant on the evaluation team pointed out that the child was conversing fluently and yet had the height of a one year old! The mother confirmed that the child was 4 years old. It was clear that the growth monitor had missed severe stunting. Children are often not weighed and measured properly, and mothers are seldom counselled. The training curriculum was not available for the evaluation team to determine the proportion of training time spent in practical exercises.

In addition to the problems in measuring children, routine data collection with the "Road to Health" cards is incomplete and scanty. There is a tendency to leave out the immunisation information as well and the importance of retaining the health cards is not underscored. The end decade MICS stated that only slightly more than 51 per cent of the children currently vaccinated against childhood diseases had health cards.

The constraints in GM at the clinic level bring up the question of reporting. It is very difficult to assess the level of accurate reporting when the results of the practical exercise of measuring weight, height and assessing the Z-score might be incorrect in the first place. The only reliable nutrition data would be that reported from household surveys where the enumerators have been specially trained for the exercise.

4.3.5.3 Supplementary Feeding

In the SCZ, UNICEF implements a supplementary feeding programme (SFP) in selected sites in the different regions. UNICEF supplies "Supermix" and high protein biscuits for malnourished children identified at the MCHs. Children who are below 2 standard deviations (or below 80 percent of the expected weight for height) are selected for SFP. World Food Programme (WFP) supports UNICEF's SFP by general food distribution to the families of malnourished children so that supplies provided for the malnourished child do not feed the whole family.

Based on nutritional surveys, WFP identifies sites for distribution of supplementary food for malnourished children, most commonly in the SCZ. The NW and the NE zones are now considered to have a relatively settled population which has overcome the effect of a war situation and therefore less likely to suffer from major variations in nutritional status of the children.

Despite this joint effort of UNICEF and WFP, malnutrition rates in the SCZ remain high. End decade MICS report that while the global malnutrition rate for Somalia is 17.2 percent, 21.2 percent of the children in the SCZ are moderately malnourished and 4.6 percent are severely malnourished by weight for height.

Food supplements are distributed once a week by WFP and as soon as the nutritional status of the children improves, they are discharged from the feeding programme. A separate registration card and register has been established for the SFP. The evaluation team noted children recruited into the SFP tend to be readmitted repeatedly, therefore making it difficult to assess the usefulness of the SFP.

UNICEF now has an agreement with FSAU (Food Security Assessment Unit) to carry out food analysis and to document long- term trends on crop production so as to allow for early preparedness for food crisis situations.

4.3.5.4 Health Education and Promotion

The KAP survey carried out in the NW in 1998 stated that a large proportion of nomadic populations received their knowledge on health issues through health education materials. Other reports also state that final decisions on health issues like referral to hospital are made at the family level. Therefore education of families is paramount to appropriate decision making. UNICEF's project proposal of 1999 planned a multi-channel focussed approach to IEC based on selected topics like utilisation of immunisation services, knowledge and use of ORT, exclusive breastfeeding for about six months and the importance of micronutrients. Emphasis was to be on production of dramas, radio messages, and use of religious and traditional opinion leaders. **The evaluation team found no evidence of this IEC initiative.** There is no indication that increased immunisation coverage in the SCZ or the increased distribution of Vitamin A to mothers is a direct consequence of the IEC and health education. These seem to be related to distribution of vaccines and Vitamin A by mobile teams.

Health education materials, generally posters, are apparent at all the health facilities including the health posts. However there are no materials for mothers to carry away and share the knowledge with others.

The only health facility found by the evaluation team with food demonstrations with locally available foods was Burhakaba MCH, supported by World Vision. IMC plans to support the introduction of backyard gardens and poultry keeping in order to promote balanced feeding, but this programme has not yet begun. Both of these activities are independent of UNICEF's support.

4.3.5.5 Supplementation of Iron & Vitamin A

MCH kits, which are supplied by UNICEF, include supplies for replenishment of micronutrients like iron and vitamin A for mothers and children. UNICEF's estimates for drug orders are based on the number of functioning facilities and the supply of kits is pegged to the production of a monthly morbidity report. However UNICEF has no mechanisms for

verifying the utilisation of these supplies or the impact of these supplies on the mothers. UNICEF often responds to requests for extra supplies, but it is difficult to verify the specific needs of different areas due to a lack of data.

At Shalembot MCH (in Merka district-SCZ), the staff only gave mothers one month's supply of iron (or even less.) The explanation given for this practice was that the stock of iron in the MCH kit was inadequate. A quick calculation of the numbers of mothers attending antenatal clinic vis a vis, iron stocks in the kit revealed that there was enough iron to give each mother a three month supply. It is difficult to determine if this is a widespread problem. Iron supplementation was not included in the end decade MICS.

Vitamin A supplementation was included in the end decade MICS, and showed that UNICEF had made great progress in the implementation of this intervention with the NIDs. In the North West, the 1996 MICS found that only 4 percent of children between 5 and 59 months had received Vitamin A supplements in the months prior to the survey. This was increased to 50.5 percent by the end decade MICS. For the North East, the coverage was 7 percent in the 1998 MICS and 35.6 in the end decade MICS. In the SCZ, (for which there is no baseline), the end decade MICS was 35.1 percent. For the nomadic population the coverage rates went from 1 percent to 28.2 percent.

Vitamin A Coverage of Children aged 5 to 59 months

Zone/Group	1996 MICS	1998 MICS	End Decade MICS
North East	4%		50.5%
North West		7%	35.6%
South & Central			
Nomads	1%	1%	28.2 %

These statistics are the result of UNICEF's decision to "piggy-back" Vitamin A distribution on the immunisation programme. This was an excellent decision that should reduce morbidity in children covered.

4.4 Addressing Health & Nutrition Needs of Somali Children & Women

The overall goal of UNICEF's Health and Nutrition Programme for the past two years has been to "reduce the under five mortality rates, reduce maternal morbidity and mortality in Somalia". The interventions specifically target children and women in the population at large rather than just target areas. Data regarding vulnerable and disadvantaged groups like the poor, those with minimal income, malnourished children, single mothers, nomadic tribes and children of these groups are not easily available.

UNICEF's objectives for strengthening the health services and expanding the immunisation program specifically addresses the needs of children and mothers.

However UNICEF's objective for strengthening reproductive health services remains largely unmet. There was no evidence of increased attendance to antenatal clinics, improved

access to reproductive health services, increased availability of qualified midwives or increased use of ferrous/folic in pregnant women. The only objective that may have been met is the increased immunisation of pregnant mothers, which can be attributed to the strong efforts of the EPI programme.

The nutrition programme is specifically targeted to children under five years. Again, there is no evidence that the UNICEF program is having any effect on malnutrition. **Malnutrition rates in the North East and the North West have increased over the past few years.** The end decade MICS shows that SCZ has higher rates of global and severe malnutrition despite the feeding programmes.

A major element of the nutrition programme is promotion of breastfeeding, but the end decade MICS show that there has been very little positive behaviour change with 21 percent of children 0-3 months of age being exclusively breastfed. Among the nomadic population the proportion of mothers who exclusively breastfeed their infants is 14 percent.

The end decade MICS showed dramatic increases in Vitamin A supplementation. Again, this increase is due to the strength of the EPI programme rather than to improvement in nutrition education.

Health education and the promotion of ORS may have contributed to behaviour change and adoption of appropriate management strategy for diarrhoeal diseases at community level. Use of any recommended treatment was reported by 67 percent of mothers (70% in SCZ, 78% in NW and 53% in NE). ORT use in the NW increased from 11 percent in 1996 to 45 percent by 1999, but there was little difference in the NE. **Still in all zones, bottle milk is given to children with diarrhoea more often than ORT.**

5 LESSONS LEARNED AND RECOMMENDATIONS

5.1 Policy, Strategy and Plans

The evaluation clearly reveals that there is substantial variation in Zonal and local capacity to implement health programmes. While the health policy and strategic plan for Somalia are well formulated, **the strategies to achieve programme objectives need to be carefully and explicitly adapted to the organisational and institutional contexts between and within each Zone.** In practice, this means a modified strategic plan with clear priorities and operational plans for each Zone and for many Districts. Major obstacles in achieving this are the attitudes and practices of the leading donor agencies with offices in Nairobi. Specific steps to address this situation are:

- (i) A reduction in the frequency and scale of meetings in Nairobi which require monthly trips from Somalia to Kenya.
- (ii) A stronger commitment by all donor agencies to support Zonal administrations in the NW and NE. This could include setting targets (and allocating resources) for the gradual transfer of responsibility of specific functions to them.
- (iii) Increasing the number of international staff in the Zones. It also means that those recruited for these positions have the requisite skills in public health planning, management and training and are organisationally and personally committed to improving local capacity and responsibility.

UNICEF and its international partners have neither the mandate nor resources required to manage and assist implementing agencies to deliver a full range of basic health services to the entire population in each Zone. **UNICEF is already trying to accomplish too much with too few resources** and needs to refocus and prioritise its interventions. For the purposes of this and future evaluations, it is neither fair nor useful to hold UNICEF responsible for the achievement of service delivery targets or project impact. These objectives are important to assess but should be carried out within the appropriate administrative and/or geographic boundaries. In view of the current limitations on the quality and quantity of data, measurement of impact on health status is a difficult and costly exercise.

Health sector reform strategies and operational plans need to be more precisely formulated in terms of actual capacity and resources available. This includes taking account of the knowledge and skills of the Zonal health authorities and the other organisations delivering health services. **Priorities and targets need to be formulated separately for each Zone.**

The private health sector (including pharmacies) provides a very large proportion of health services. An unformed and uncontrolled private sector is not in the interest of the Somali people and can result in an inefficient and ineffective use of household resources spent on health services. **Policy and plans need to address the role and responsibilities of the private sector in the provision of safe, low cost drugs, accurate information to clients, and both curative and preventive services.** They should address specific measures to protect the public from abuse, fraud and excessive costs and how public sector resources can

be used to improve the services and products provided through private practitioners and suppliers of pharmaceuticals.

Problems in the quality of services and the quality of management are widespread. While improved systems and supervision can improve the situation, **UNICEF and its partners need to give more attention to long range capacity-building activities**. This includes the establishment of training centres in each zone staffed by health professionals skilled in both technical subjects, the management of health systems and facilities, and pedagogy.

5.2 Organisation, Management and Human Resources

Within the donor group, UNICEF has played a central role in the provision of primary health care in the last five years. The shift of focus from emergency to development in the NW and the NE has offered new opportunities to gradually shift the overall responsibility of provision of health care to the administrations in place. In the SCZ, the inclusion of non- governmental and the community based sector is paramount in the provision of health care.

The problems of co-ordinating and supporting a large number of INGOs, local NGOs and different administrations in each Zone is an extremely complex task. Implementing agencies must respond and adapt their activities to a variety of donors and project objectives. This, when combined with the high turnover of staff and the limited institutional memory makes co-ordination extremely complex and time consuming. More attention and resources should be given to the decentralisation of programmes, Zonal level co-ordination, increased supervision of activities and capacity-building. In order to achieve this objective, UNICEF and other funding agencies should consider:

- (i) Increased participation of organisations (universities, consulting firms and INGOs) with a track record in institution-building projects. At present, the emphasis is to fund agencies able to deliver services and which have limited experience in working on larger scale planning and capacity-building projects.
- (ii) Additional management and TOT training targeted to implementing agencies including NGOs and local authorities.
- (iii) Increased emphasis on coordination, planning meetings in the Zones and a reduction of the field staff time in Nairobi. This is particularly important as the capacity-building of local administration and Somali-based organisations is given a higher programme priority.

In spite of the initiative to link the supply of drugs to the receipt of timely reports, there continue to be delays in reporting. There does not appear to be a simple remedy to this problem other than continued pressure from UNICEF on the implementing agencies and perhaps the refusal to continue to fund those agencies who continually fail to meet their administrative obligations. In view of the limited number of organisations willing to work in Somalia, however, this sanction may not be easy to apply.

USAID is the major funding agency for UNICEF. One of USAID=s main concerns is UNICEF=s relationship with its partners. The evaluation team recommends that UNICEF steadily builds a relationship in the NE that is similar to the NW, where the administration has full confidence in its partnership with UNICEF. The UNICEF H&N project officer in the NE has already started working closely with the Director General to resolve the misunderstandings of the past.

The situation is different in the SCZ. To begin with, UNICEF is over-stretched in terms of staff and secondly, it assumes that the presence of International staff of the NGOs will implement activities as per project agreements. However agencies are often tied by conditions from their own headquarters, weakening their ability to fully adhere to agreements with UNICEF. In the SCZ, it is recommended that UNICEF establish a closer collaboration with its partners in an effort to establish an equilibrium in achieving targets required by their own headquarters, USAID and UNICEF.

One lesson that emerges from this evaluation, and cited in prior reports, is the need to balance interventions and strategies between service delivery and capacity building. This is particularly complex in a situation where the shortage of literate, trained health personnel is acute and where the public sector is embryonic with limited capacity to assume its responsibilities. Balancing interventions is particularly difficult in Somalia where half the population is nomadic and the cost of essential preventive services such as immunisations and the provision of a supply of potable water is very high.

All of these complexities are exacerbated when key positions are left unfilled and/or filled by temporary staff.. UNICEF needs to address and resolve its staffing problems. If UNICEF can fill its positions with qualified professionals contracted for longer multi-year assignments, it can provide the necessary leadership and institutional memory to its local and international partners. UNICEF should decline the temptation to “steal” staff from NGOs in order to fill vacancies, especially for short term assignments.

Consideration should be given to recruiting Somali professionals now resident in other parts of the world. This approach may be able to obtain significant financial support from European nations which host large numbers of professionally trained Somali refugees.

5.2.1 Supervision and Monitoring

UNICEF=s weakness in supervision and monitoring has often led to contradictory impressions of achievements in the field. In the NW, the H&N project assistant has developed a set of supervision checklists, which were circulated to partners for comments. In order to improve the quality of delivery of health services, UNICEF should consider the development of options for joint and independent supervision by partners. UNICEF could develop a policy for supervision and monitoring which is linked to its agreements with partners and subject to review before renewal of agreements.

5.2.2 PHC and MCH Guidelines and Standards

The evaluation team noted that PHC and MCH guidelines had not been distributed in the field. Among those who had either seen or read a copy, were NGO employees working at the regional offices. It appears that the guidelines which took many years of collaborative work among UNICEF, the SACB and the full range of partners, have not yet been properly implemented. In many places in Somalia most of the learning institutions have been destroyed and the only access to modern learning is through teaching materials provided by donors. The MCH and PHC guidelines are needed to support management and training activities. It is recommended that the guidelines be distributed to the Zones and to all partners and that health personnel and management be trained in their use. The translation of selected guidelines into Somali language may also ensure wider reading and reference to these documents.

5.3 Information Systems

The overall goal of UNICEF's Health and Nutrition Programme for the past two years has been to reduce the under five mortality rates, reduce maternal morbidity and mortality in Somalia. The interventions target children and women in the population at large rather than just target areas. Data regarding vulnerable and disadvantaged groups like the poor, those with minimal income, malnourished children, single mothers, nomadic tribes and children of these groups are not readily available. This means that the requirement for accurate information, the data needed for planning and evaluation, is not likely to be met, at least not in the medium term. Figures cited for population vary significantly, over-counting is a long established Somali tradition (they know higher numbers may lead to higher levels of aid), literacy is low and outside of the donor community, little value is placed on statistical accuracy.

Somalia's population figures vary significantly according to the different reporting agencies. This makes it difficult for implementing agencies to estimate a realistic denominator for the target population. Only recently all UN agencies started using estimates established by UNDOS.

Based on these estimates, in the last two years, UNICEF has made an effort to set targets for all planned activities. In the process UNICEF has addressed USAID's concern about the targeting of funds and whether UNICEF is implementing as per the agreements. The question here is whether UNICEF's partners implement as per their agreements. This is difficult to determine under the present circumstances. It is recommended that UNICEF develop a supervision and monitoring system in collaboration with the partners with identified indicators for each area. In the SCZ, with some improvements on the newly developed agreement preparation form, UNICEF should be able to estimate what can be achieved in a set time frame.

The development of the HIS is at different stages in all the three zones, so that SCZ was already producing annual summary reports while the NW had not been able to enter data. Unlike most health information systems, in general, the HIS is functioning fairly well, mainly due to UNICEF's arrangement to provide drug kits only to health facilities, which do

regularly submit the monthly reports. Once the HIS is in place in all the zones, UNICEF=s main goal should be to develop other elements of the HIS like data collection registers and supervision checklists.

One modification that may make the HMIS more useful would be to adapt it to both Emergency and Development contexts.

5.3.1 Management and other Indicators

The information system needs to be expanded to include more information on management issues, community participation, financing and training. At this early stage in the rebuilding of services in Somalia, it is important to have information on what is accomplished to strengthen local capacity, to improve the quality of services, and to increase the medical and management skills of those delivering services and managing resources. Data on the number and types of equipment and their status (functioning, in need of repair etc.) would also help all stakeholders to understand and assess the type and scale of their problems.

Another recommendation is for UNICEF to modify the objectives and indicators used in the project agreements with implementing agencies. These should be carefully adapted to the health priorities and institutional conditions in the project areas.

5.3.2 Geographic Information Systems (GIS)

One of the major problems in the formulation of health programmes and is the lack of accurate and comprehensive data on the distribution of health resources and population. GIS software and technology can be used to organise these data into a common framework using standard criteria, and to make them available to planners and managers to strengthen decentralised health planning, monitoring, evaluation and disease surveillance. UNICEF and the other agencies working in Somalia have not made effective use of the Geographic Information System unit operated by UNDOS. This unit has functioned for many years but has not been adequately integrated into the planning and management systems. The failure to use this resource reflects the lack of understanding on the part of the many partners as to the utility of a GIS system in health planning and management.

Health and population information in Somalia is collected by UN agencies, local authorities and NGOs. There is some variation due to various reporting requirements and incomplete standardisation of criteria, and the methods of data collection used by these organisations often differ. Some use GPS devices to collect locational data and questionnaires to capture attribute information (e.g., numbers of health personnel, vaccination records and outpatient attendance in the health facilities). Many organisations based in Somalia share their data with UNDOS which uses it to develop geographic and attribute databases for health and population. The main variables in the UNDOS health and population database are shown below:

- Name of health facility.
- Classification of the facility (Hospital, MCH., Health Post, etc.);
- Personnel by major classification (e.g., Doctors, Nurses, Auxiliary staff);

- Estimated population in the catchment area for each health facility.
- Population by Zones and lower level administrative units.

Apart from the health and population database, UNDO's GIS database includes data from old maps of Somalia, satellite materials, and information published by GIS companies abroad (ADC map). UNDOs, shares its GIS data with the collaborating UN agencies and NGOs without charge. Generally the databases contain incomplete and inaccurate data which needs to be updated every time they are used for special surveys or projects.

The health and population database for Somalia developed by UNDOs was reviewed and found to have many limitations for GIS analysis and health planning. The incompleteness of the data sets and lack of information for levels lower than districts (e.g. villages) are among the major issues that need to be addressed before any reasonable GIS analysis can be undertaken.

To make more effective use of this resource, the UN agencies and other organisations working in Somalia need to make a concerted effort to collaborate with the GIS office and to formulate specific requests for maps and geographic analysis. In turn, they will have to provide the office with up to date, accurate information of the resources and their distribution. The following variables need to be included:

- Type of agency that operates the facility (Zonal authority, UN Agency, NGO, Private etc.);
- Administrative boundaries to the village level when possible;
- The delineation and analysis of actual and potential catchment areas for each health facility;
- Population in catchment areas;
- The location and type of health facility;
- Physical conditions (water, electricity, laboratory etc.);
- Health services provided (curative services, FP, EPI, STD/AIDS etc.);
- Data on utilisation, vaccinations etc.;
- The incidence and prevalence of major diseases;
- Data on all categories of health personnel and their work stations;

When this information is provided to the UNDOs GIS Unit they will be able to produce maps and tables that display and summarise the data. The maps and statistics will facilitate and improve the effectiveness of health planning, monitoring and evaluation activities by all stakeholders in Somalia. They will also be useful to NGOs, private sector organisations and donors who wish to target their programs and services to areas that are in most need of assistance.

5.4 Health Sector Reform and Health Care Financing

UNICEF has successfully supported the health sector reform process in Somaliland (NW Somalia) and is now also working with the Puntland Administration (NE Somalia) to strengthen policy and planning activities. These capacity-building activities need to be intensified as a matter of priority in these Zones and with the new administration in Baidoa. Progress has been made to improve the level of community participation and cost recovery

for drugs and services. The results indicate that the programs can work and can provide the public sector with additional resources for the expansion and improvement of health services.

The efforts to introduce and expand cost-sharing initiatives have, however, moved slowly. One reason for this is the failure of the donor community to make effective use of the recommendations in the report on Health Care Financing (Development Solutions for Africa 1997), the follow up project proposal produced jointly by the major funding agencies and partners, and recently incorporated into the Strategic Plan for the Health Sector in Somalia (2000). It reflects one of the underlying shortcomings in the effort to improve health in Somalia – the large number of diverse organisations and interests, and weak leadership due in part to high staff turnover.

The recommendation is to design and implement a project to co-ordinate and support Somali authorities, NGOs and other agencies to carry out health financing activities. It should address the following issues.

- The integration of health financing and cost-recovery activities into the plans of Zonal Health Administrations and other implementing agencies.
- Strategies to increase the cost-effectiveness, accountability and financial sustainability of health programs and services at facilities.
- The design and implementation of management and operational support systems for health financing adapted to the political, economic and cultural contexts in each Zone and at each type of facility.
- The design and implementation of continuous training programs to improve the managerial skills of persons involved in the administration of health resources.
- The design and implementation of monitoring and evaluation and IEC systems.

A critical issue that must be addressed in connection with health financing and cost-recovery activities is the improvement in the quality of services. Experience has shown that the willingness of clients to pay for services is linked to their quality and for both ethical and financial reasons, this dimension of the program must be addressed along with the managerial components. In view of the limited level of donor funds and those presently available to the public sector in Somalia, an effective cost-sharing programme is essential for the long term growth and sustainability of health systems in Somalia.

5.5 Specific Programmes

UNICEF needs to prioritise its interventions and to focus on those which it can do well. These include EPI and NIDS, and the Essential Drug Programme. These programs need more vigorous monitoring and supervision, more training of local counterparts, and more attention to collaborative decision-making. UNICEF's Nutrition and Reproductive Health initiatives should be scaled down and emphasis should be redirected to collaboration with and support of the WFP and UNFPA programs.

5.5.1 EPI and NIDS

UNICEF's major achievement has been the establishment of a regular supply of vaccines. The strategy of supporting partner agencies with cold chain equipment, supplies, vaccines and training has proven to be successful in achieving high immunisation rates in a very difficult setting. The combination of static and mobile sites is important for providing equity in vaccine access to nomads and dispersed populations as well as urban populations. "Piggy-backing" Vitamin A supplementation to EPI has resulted in dramatic improvements in coverage of this micronutrient.

UNICEF has proven that the private sector can provide immunisations, and local authorities can be responsible for logistics. Local NGOs can be effective partners for UNICEF, and UNICEF can insist that preventive and promotive services be included at the health facilities the local NGOs support. Availability of drugs at static sites seem to be necessary to draw mothers and children to a facility for vaccination.

Guidelines for immunisation practices and cold chain maintenance need to be available in the field at all vaccination sites, need to be reviewed regularly by staff responsible for immunisations, and need to be referred to during supervisory visits. UNICEF should immediately distribute and train its partners to use the immunisation guidelines; these include those for cold chain maintenance, vaccine wastage, immunisation techniques, and logistics. UNICEF and its partners should monitor the use of the guidelines the field during supervisory visits. UNICEF should continue organising refresher courses for the staff to reinforce principles of vaccination and immunisation. The guidelines should be used in the courses and during follow-up supervisory visits to evaluate the effectiveness of the training.

Supervision and monitoring are essential to maintenance of the cold chain. Breaks in the cold chain cancel out successes in reaching vulnerable populations. UNICEF should strengthen its cold chain management system and establish a preventive maintenance team for each zone with its own logistic support. Preventive maintenance training can be extended to EPI trained staff in all the regions so that minor breakdowns in the equipment do not lead to major breakdown in service delivery.

UNICEF should strengthen the HIS system in the vaccine stores so that stock lots can be easily estimated. UNICEF should also implement a system for monitoring of vaccine use and wastage in the field.

NIDS is an international initiative that **will** continue in Somalia until polio is eradicated. **It can be seen as an opportunity or as a threat to on-going immunisation programs.** UNICEF has the opportunity to lead the discussions on the planning and organisation of NIDS so that it is a benefit to the women and children of Somalia. Planning for NIDS needs to be on-going, all year long so that partners are involved and ready to contribute to NIDS in a positive way. UNICEF/WHO should revisit the NIDS strategy to address issues of concern to UNICEF partners and to develop a more collaborative planning with partners. A major issue to be addressed is remuneration of staff.

Discussions of additional elements, such as Vitamin A distribution and measles immunisation need to be a part of these discussions. Adding too many things to NIDS would burden it and

jeopardise its success. But a decision to expend so many resources only to protect children from one disease in a country with so many needs cannot be taken lightly. All opportunities must be explored.

5.5.2 Health Information Campaigns and Community Participation

UNICEF has been instrumental in initiating and implementing successful health information campaigns especially during disease outbreaks like cholera. However, these kind of campaigns tend to be short-lived, without any residual behavioural change among the population, thereby creating the need to invest and repeat similar activities. Health education campaigns conducted through organised communities will yield more lasting results and create opportunity for community education.

UNICEF has already decentralised its administrative structure in Somalia and its field offices have the authority to take decisions to adapt activities to local conditions. This is not true for most (if not all) partners with more centralised administrative systems. In practice, this makes it difficult to achieve effective and timely co-ordination among stakeholders at Zonal and lower administrative levels.

UNICEF and its partners need to clarify these distinctions between disease specific information campaigns, IEC and social mobilisation strategies and community participation. While it may not be within the capacity of UNICEF to initiate social mobilisation, some of its partners have already changed to this approach (e.g., World Vision in Burhakaba and IMC in Huddur). Social mobilisation followed by community participation is a slow but effective process in sensitising communities to take responsibility to ensure their own health. They should be central to all community based Primary Health Care activities. Suggestions to this approach are stated under new initiatives.

5.5.3 Nutrition

The nutrition programme has not proven as successful an intervention for UNICEF. Because different methodologies are used for nutrition surveys, malnutrition rates are difficult to know. But the data (keeping in mind the quality of the data) suggest that malnutrition has become a greater problem over the past five years in all of Somalia.

Nutritional survey methodology should be standardised so that data can be compared over time and between different populations. While UNICEF does not have the mandate to impose methodology, it should concentrate efforts on establishing dialogue with other agencies in order to achieve this goal. (During review of this document by UNICEF, it was reported to the evaluation team that this is finally happening.)

Problems in UNICEF's nutrition programme have been exacerbated by unfilled staff positions. In addition, there is confusion between the supplementary feeding programs of UNICEF and WFP. UNICEF's feeding programme should only be implemented in the presence of an existing general food distribution programme in response to changes in the nutritional status of the children. UNICEF needs to modify its strategy and strengthen it

collaboration with WFP so that nutrition activities of WFP are fully integrated into the MCH programme supported by UNICEF.

In the long run, UNICEF's aim should be to reduce the number of feeding centres, as there is no substantial data to show the benefits of SFP. Screening children for food distribution should be reserved specifically for emergency interventions rather than an activity of the routine MCH services.

The major thrust of UNICEF's program, to encourage breast-feeding and proper weaning appears to have had no effect on the target population. Bottle-feeding continues to be widespread.

The Master Plan of Operations for 2001-2003 does not address the issue of promotion of breastfeeding specifically nor does it put any emphasis on nutrition education and promotion for the community level. UNICEF's efforts should focus on the promotion of breastfeeding and initiating food demonstrations at the facility and community level (through community mobilisation and IEC activities) as part of nutrition education to mothers. The issues of micro-nutrient supplementation has been addressed partially well with the EPI programme but the larger problem is the basic provision of well balanced feeding habits. UNICEF should encourage selected partners to support a community based approach(as pilot areas) for improving the nutritional status of children through nutrition education, promotion of breastfeeding, hygiene and sanitation.

The planned multimedia IEC intervention should be developed and implemented.

Routine growth monitoring at MCH facilities is laden with errors, conflicting guidelines and poorly trained staff. **Growth monitoring is a complex intervention which requires high levels of supervision and training.** It includes training in how: to weigh and measure small uncooperative infants and children, to plot the measurements on the Road to Health Card and facility data sheets, to interpret the data, to diagnose and treat the child and how to counsel the parents. It is far too complex an intervention for an organisation as over-stretched as UNICEF to attempt to implement in the large number of MCHs. Done poorly, it merely wastes precious resources. This is one area UNICEF should leave to others as it concentrates on the programmes it does well.

5.5.4 Reproductive Health (RH)

UNICEF's reproductive health initiative has not achieved its goals of reducing maternal morbidity and mortality. However, UNICEF is to be commended on funding a study that showed that TBA training has little effect on maternal mortality. RH is another area in which UNICEF should reduce its activities, objectives and goals so that it can concentrate on what it does best. One option for UNICEF is to support and partnership with UNFPA. In the NW, UNFPA has an ongoing programme with CARE international for strengthening reproductive health services.

5.5.5 Distribution of Drugs and Supplies

UNICEF has had difficulties with this programme over the years and there have been many complaints of the distribution of expired drugs. The programme had too little monitoring and supervision by UNICEF staff. Recently, UNICEF began to address these problems and

during the evaluation, **no expired drugs were found in the facilities.** This suggests that appropriate staffing, monitoring and supervision can make the program work and that UNICEF can effectively respond to critical feedback.

The program should continue to be strengthened. It is greatly appreciated by partners, especially the government administrations in the North West and North East and local NGOs and CBOs. It is contributing to cost recovery, and draws mothers and children to MCHs so that they can receive preventive services.

While the drug kit system used has drawbacks, it contributes to the quality of the medications being distributed. Systems of bulk drug ordering and distribution would not only be more logistically difficult to administer, and the health information system is currently inadequate to support it.

6 NEW INITIATIVES

Some of the new initiatives presented below are already discussed in other sections of the report. This section highlights some of these and identifies additional ones to be considered.

6.1 Human resource development/capacity-building.

In an attempt to support the development of a sustainable health care system, UNICEF should increase its promotion of stakeholder participation at all levels. In areas of stability like the NW and the NE, UNICEF's role would be to expand and improve the quality of stakeholder participation in planning, implementation and monitoring of health related services. . A start towards this has been made in the Bari Region with the establishment of the Inter-District Human Resources Development Centre which trains CBHWs and MCHWs.

Specific initiatives and training interventions need to be targeted to:

- Zonal, Regional and District administrative authorities;
- Existing training centres (i.e., the one in the Bari Region);
- The private sector;
- The staff of local and international NGOs.

UNICEF is the largest provider of training in Somalia. With the recent preparation of a training plan by all partners, duplication and overlap of training has been reduced. With only one recently established formal learning institution, there has been almost no increase in the number of trained personnel. Auxiliary staffs receive short training just to manage the tasks they are in charge of. In view of this situation UNICEF should;

- **Continue and expand short-term training** of local administrative, professional and auxiliary staff. These should address the medical, public health and management topics covered in this report as well as others identified by donor agencies and stakeholders in the field. In addition, attention should be given to upgrading basic skills in the diagnosis and treatment of the most common diseases since acute illness episodes are usually the primary reason for seeking care.

- **Support the operation of existing, and establishment of new Zonal and Regional Health Training Centres and the training of a cadre of teachers and administrators to work in them.** The focus of short-term courses initiated under emergency programmes and adapted to current activities should be supplemented by a coordinated, institution strengthening/building strategy. This should be given high priority by UNICEF, USAID, the EU and other major donors and will require the contracting of individuals and institutions with the necessary experience and expertise. Very few NGOs have the capacity to take the leadership in this initiative and the donor community should not add this to the already high burden they have in service delivery.
- **Support the production of training and learning materials** for managers, health professionals and auxiliary staff. This is required for both the short-term training and as part of the capacity building activities for existing and new Health Training Centres. A huge volume of materials already exist and the key activities are editing, translation into the Somali language and adaptation of selected items to reflect the local context.
- **Administration, Management and Finance.** External funding of Somali health systems is likely to continue for many decades. In view of the multiple reporting and accounting requirements, the embryonic status of Somali health administrations, and limited management skills of many health professionals, special attention needs to be given to these topics. In addition to the basic coursework, the Somali health leaders need to be adequately trained in the policies and administration of international and NGO programmes, health planning and budgeting, licensing of health practitioners and those who sell drugs, and cost-recovery. Many of these topics are examined in a previous report prepared for UNICEF/Somalia by Development Solutions for Africa (1997).
- **Explore and identify opportunities and mechanisms to recruit Somali health professionals living outside the country.** Many trained Somalis are now working in other countries. In view of the language and cultural issues involved in working in Somalia and the need to increase capacity-building activities, UNICEF, other donors and INGOs should make a serious attempt to recruit these professionals to work in international and Somali agencies. They should be given the appropriate level of remuneration and other benefits and contracts for several years. This may be a better investment than the extensive use on other expatriates who lack the cultural and linguistic skills and who tend to stay for short periods. This would have to be done keeping in mind the clan differences in the various zones.

The recruitment of expatriate Somalis should be considered as essential to the staffing of health training institutions in the Zones. While foreign health professionals can make important contributions to the institution-building effort, the linguistic and cultural challenges can most effectively be met by Somalis, particularly those who have training and experience in countries with established health care systems.

At this point in time, **the training of Somali health workers including local professionals should be done in-country.** This is due to the tremendous need to improve basic medical, public health and management skills of large numbers of people. In addition, experience from other parts of Africa indicate that large numbers of staff trained abroad do not return to

their home country and in view of the large demand for health professionals in other nations, the investment for overseas training for Somalis does not appear to be a cost-effective option.

6.2 Community mobilisation and participation.

UNICEF's future programmes should include a strong component of community mobilisation and capacity building at the community level. Somali communities have a strong tradition and their own way of managing household and group resources. Some agencies have already selected this strategy for implementing their PHC programs. This component should also be part of other partner agreements and monitored by UNICEF field personnel. In preparation for this approach, UNICEF's prior arrangements would include the following:

- Identification of realistic models of operation for involving communities by using participatory techniques (PRA, PANS);
- The development of guidelines for establishing District Health Management Boards, Health Facility Management Committees, Village Health Committees and other local support organisations;
- The production of guidelines for introduction of cost sharing and user fees;
- Capacity building for communities in management and monitoring skills.

In order to reduce dependency on donors, UNICEF should set criteria for identification of local partners for future agreements. As areas of Somalia become relatively stable following Awar fatigue and movements of population decrease, there will be an emergence of organised groups of settlements in urban towns. These new settlements are appropriate for introducing new initiatives in community mobilisation. Community decision making would become a cornerstone in transfer of responsibilities to communities.

One issue often raised by implementing agencies and donors is how to increase participation and use of health services within an administrative and/or project area (a target population). Evidence from this and previous studies indicate that the tribal and clan affiliation of the service providers is sometimes a factor. In some cases, those at the health facility concentrate their efforts towards one segment of the catchment population, in others, clients are reluctant to seek assistance from health workers to whom they have no social ties. One way to address this problem is to include data on the social groups in the catchment areas and **to make a special effort to see that members of each are trained and recruited to work at the facility and/or in the outreach programmes.** While this may mean "less qualified" personnel may have to be recruited in some instances, this compromise will increase participation and service utilisation in most parts of the country.

UNICEF and other agencies need to be sensitive to the fact that the success of local participation including cost-recovery places an additional responsibility on health facility staff and local health authorities. In brief, their sustainability requires real improvements in the quality of services at NGO and government facilities.

6.3 Initiatives for the Private Sector

The private sector in Somalia (traditional and allopathic medical practitioners; herbalists and small shops that sell drugs) have been and will continue to be the major provider of health services. Somalia has never had an effective and equitable public health programme and it will take decades to establish basic public health systems in the Regions, Zones and Districts. In short, it is both desirable and necessary for the donor, NGO and Somali agencies to take into account the actual and potential role of the private sector in the delivery of health services (including public health services, the sale of drugs, laboratory and other diagnostic support services). This is a difficult challenge since the policy and practice of most development agencies is to work with and through government institutions. In addition, most expatriates involved in health sector assistance and development view health as a public good to be supported through government resources.

In addressing the private sector from a “public” perspective, it is useful to keep in mind that a well trained and effective private sector will attract patients who can afford to pay for health services. It should also facilitate the targeting of scarce government resources to preventive and promotive services, and help focus curative services to the poorer segments of the society.

The paragraphs below highlight a few initiatives that could be taken to expand the scope of health sector development to the private sector. They are, however, a short and preliminary set of activities and not a substitute for a much needed investigation and analysis of the issue.

- **Regulation and Certification.** This includes the production of regulations (and eventually laws like the Health Act in the NW) to ensure those involved in the delivery of health services have a minimum level of training and competence and that the drugs they supply are appropriate and low cost. Laboratory services should be included..
- **Education and Training.** A continuing education programme linked to the future renewal of licenses for private practice would encourage service providers in improving their diagnostic skills, prescription practices and patient education. The training of private sector personnel in the selection, procurement and storage of effective low cost drugs should also be considered. In addition, the planning and implementation of basic and continuing education courses should encourage and allow for the participation of private sector health providers. The training of public sector employees to monitor and evaluate the activities and results of private services should be part of this initiative
- **The “Purchase” of services from established private services.** This initiative could be piloted in the NW where there are upcoming private services. UNICEF does not have the capacity to strengthen all tiers of health care delivery and its main focus is primary health care services. However the recent study supported by UNICEF on TBAs shows that services provided by TBAs will only have an impact in the presence of functioning referral services. UNICEF should explore options for “purchasing” services from functioning private sectors which fall within a selected criteria for acceptable health care.
- **Activities to help Somali health workers to create effective professional associations.** In the long term, effective monitoring and control of health services should be shared by

these groups as well as by the public sector. Professional associations can promote and help ensure that the appropriate standards are developed and enforced.

- **Reaching the nomadic populations.** IEC campaigns through radio and/or in conjunction with mobile unit visits and NIDs could provide individuals, families and traditional healers, TBAs etc. with useful information on prevention, hygiene and the appropriate names and use of drugs that are dispensed throughout the country.

6.4 Integration of a Geographic Information Systems (GIS) into the HMIS

While some may see the use of GIS technology as too “high tech” or inappropriate given the depth of health problems in Somalia, it is a very effective planning and monitoring tool and is much more effective at communicating results and problems than the standard text and table format. If properly used, GIS display and reporting can dramatically improve the efficient and equitable distribution of health services. It can also be very useful in helping health agencies to produce and communicate information on health status, resource distribution and programme impact.

The basic resource for this already is established within the UN system for Somalia but has not been adequately used. Staff of international agencies, INGOs and authorities in Somalia need much more information on how to use a GIS to improve planning, management and evaluation. This will require orientation and training programs of a least one week to get started. Additional training and possible decentralisation to the Zonal level may be possible in the future.

6.5 Selection of Partners and Contracts

UNICEF is sometimes faced with situations in which it feels obligated to work with agencies with less capacity and commitment than it considers desirable. It does, however, need to take steps to ensure that the resources they receive and support given to them are effective. This situation can be addressed by providing field staff with training to improve weaknesses and the incorporation of performance indicators into contracts. **It may be necessary for UNICEF to withhold support to a few agencies which fail to perform as a way of sending a message to others that results will be evaluated and used to determine future funding.**

UNICEF and other donors also need to expand the scope of their institutional partners to include universities and other research and training institutions in developed and developing countries. This is particularly critical to the long-term success of capacity-building initiatives including the establishment of Health Training Centres. The experience of the past decade clearly reveals that the use of a highly collaborative approach among NGOs whose primary concern and skills are emergency interventions and the delivery of basic health services is complex, slow and costly. Another level of partnership is needed to move forward quickly on the development of administrative structures and educational institutions for the health sector.

7 CLOSING COMMENT

The general direction of administrative reform and development in Somalia appears to be towards the establishment of regional and zonal authorities similar to those functioning in the N.W. and N.E. Zones (Somaliland and Puntland). Regardless of what happens in terms of the re-establishment of a centralised Somali Authority and its international recognition as a Nation-State, the political landscape will include strong Zonal administrations. This pattern is appropriate to Somali society that has always functioned on a tribal and clan basis. In view of this, the donor community and the implementing agencies should give high priority to building the capacity of Zonal, regional and district health authorities to manage and deliver health services. As part of this, increased attention to private sector initiatives, additional external collaboration, local participation and community control is recommended.

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Annex 2: UNICEF's Partner Agencies and Project Agreements

	Cooperating agency	Project title	Duration of agreement	Project location	Beneficiary population	Budget USD
1.	International Medical Corps Int	PHC/EPI Nutrition	2/00 – 3/01	Baidoa,Dinsor,Qansaxdhere, Berdale(Bay)huddur,Rhabdure,Elberde(Bakol)Beletweyne(Hiran)	Total 370,000 U5 yrs – 62,900 U1 yr – 14,800 WCBage 85,100 Preg 14,800	Total 398,113 Cash 122,467 Supplies 275,467
2.	AMREF Int	PHC/EPI/Nut	4/00 – 3/01	S&C Luuqdist.(Gedo)Abduwaq, Balanbale (G/gaduud reg)	Total 150,000 U5 yrs – 25,500 U1 yr – 6,000 WCBage 34,500 Preg 6,000	Total 255,362 Cash 15,898 Supplies 239,464
3.	COSV Int Coord. Comm of the org. for Vol service	PHC/EPI Reg.hospital,9 MCHs, 5 H/P,c/s in h'tal	2/00 – 3/01	S&C 4 dist(L/Shabelle)Merka(3 MCHs+hospital),Shalambod, Janale,K/warey,BuloMarer(M CHs)Qoroiley,Brava dist	Total 167,000 U5 yrs – 28,390 U1 yr – 6,680 WCBage 38,410 Preg 6,680	Total 193,034 Cash 66,902 Supplies 126,132
4.	MSF Spain Int	PHC/EPI	4/00 – 3/01	S&C- Jowhar,Mahacday,AdenYaba al dist(M/Shabelle reg) Yaqshid dist(Benadir reg)	Total 150,000 U5 yrs –25,500 U1yr – 6,000 WCBage 34,500 Preg 6,000	Total 106,467 Cash 12,912 Supplies 93,555
5.	Action contra la Faim Int	EPI and Nut.	4/00 – 3/01	S&C- Luuq(Gedo region),Mogadisho(Banadir) (IDP)	Total 85,000 U5 yrs – 14,450 U1 yr – 3,400 WCBage –19550 Preg 3,400	Supplies 121,601
6.	World Vision Int	PHC/EPI Nutrition	4/00 – 3/01	Salagle village Burhakaba dist. (Bay) Bualle dist. (M/Jubba)	Total 80,000 U5 yrs 13,600 U1 yr 3,200 Wcage 18,400 Preg 3,200	Total 91,988 Cash 15,182 Supplies 76,706
7.	INTERSOS Int	PHC/EPI/ Nut	4/00 – 3/01	S&C Jowhar,Warshiekh,Balad dist. (M Shabelle)	Total 60,000 U5 yrs – 10,200 U1 yr – 2,400 WCBage 13,800 Preg 10,200 check	Total 91,410 Cash 26,664 Supplies 64,746
8.	COOPI Int	Support to Coopi H/S	1/00- 12/00	NWZ Borama Awdal reg.	U5 yrs – 13,600 WCBage 11,500	Supplies 61,266

9.	Muslim Aid UK Int	PHC/EPI 4 MCH centres, 2 EPI	4/00 – 3/01	S&C Medina(Banadir)W/wein(L/S hab)Kismayo,Jamama(L/Jub ba)	Total 120,000 U5 yrs –20,400 U1yr – 4,800 WCBage 27,600 Preg 4,800	Total 57,653 Cash 8,980 Supplies 48,673
10.	TROCAIRE Int	PHC/EPI/Nut Hospital,MCH centre,EPI mobile	4/00 – 3/01	S&C Bulo hawa,Dolo dist. Gedo reg	Total 65,500 U5 yrs – 11,135 U1 yr – 2,620 WCBage 15,065 Preg 2,620	Total 55,393 Cash 8,120 Supplies 47,273
11.	CISP Int (Int Comm for the Dev of Peoples)	PHC/EPI/Nut 4 mch,4 epi, mobile EPI	4/00 –3/01	S&C El-Dhere dist(G/Gaduud)haradere dist(,Mudug reg.)	Total 60,000 U5 yrs – 10,200 U1 yr – 2,400 WCBage 13,800 Preg 2,400	Total 50,593 Cash 7,991 Supplies 42,602
12.	IFRC Int (Int Fed of Red Cross)	EPI supplies	NW/NE/SCZ	Clinics	Total 572,150 U1yr 19,453 Preg 22,886	Supplies 46,318
13.	CORDAID/MEMISA Int	PHC/EPI/Nut Hospital,2 MCH,10 H/P 2 static EPI	4/00 – 3/01	S&C Garbahrey,Burhubo dist. Gedo	Total 50,000 U5 yrs – 8,500 U1 yr – 2,000 WCBage 11,500 Preg 2,000	Total 38,543 Cash 3866 Supplies 34,676
14.	SOS hospital Int	Hospital	4/00 – 3/01	S&C Heiliwa dist. Banadir reg	Total 60,000 U5 yrs – 10,200 U1 yr – 2,400 WCBage 13,800 Preg 2,400	Supplies 37,994
15.	MSF Belgium Int	PHC/EPI/Nut	4/00 – 3/01	S&C Huddur dist (Bakol reg) Kismayo dist(L/Jubba)	Total 60,000 U5 yrs – 10,200 U1 yr – 2,400 WCBage 13,800 Preg 2,400	Supplies 27,031
16.	MSF Holland Int	KA-emergency intervention	9/00-3/01 (since -	S&C Huddur	900pts.(150 per mth)	23,835(uincef) 42,500(msf-h)
17.	NPA Int	Support to H/S	1/00 – 12/00	NW/NE Las Anod,Taleh dist(Sool)	U5 yrs 4,420 WCBage 3,735	Supplies 13,170

18.	Mercy USA Int	EPI	8/00 – 11/00	S&C Jilib dist M/Jubba reg	Total 25,000 U5 yrs – 4,250 U1 yr – 1,000 WCBage 5,750 Preg 1,000	Total 10,232 Cash 5,631 Supplies 4,600
19.	IAS Int (Int Aid Sweden)	School clinics	4/00 – 3/01	S&C Dharkenley, Madina, Yaqshid Waberi, Hamar, JabJab (Banadi rKm18, Km50 (L Shabelle) Mahaday dist (M/shabelle)	Total 2000 Banadir 1300 Shabelle 700	Supplies 3,891
20.	World Concern Int	PHC/EPI/Nut	7/00 - 12/00	S&C Kismayo, Jilib dist. M/L Shabelle reg	Total 10,000 U5 yrs – 1,700 U1 yr – 400 WCBage 2,300 Preg 400	Supplies 1,902
21.	Cooperative New Ways Int	Health Post	6/00 - 11/00	S&C Merka dist, (L/Shabelle reg)	Total 10,000 U5 yrs – 1,700 U1 yr – 400 WCBage 2,300 Preg 400	Supplies 1,379
22.	Somalia Red Crescent society (National)	Epi and Nut	4/00 – 3/01	S&C Baidoa, Q/dere, Berdale, Kisma yo, Jamama, Badade, Jilib, Gad uday, Dusamereb, El- bur Galinsoor, Adado Afgoi, Balad of Bay, L/M Juba, G/Gaduud, Shabelle (L/M) regions	Total 553,000 U5 yrs – 94,010 U1 yr – 16,590 WCBage 27,190 Preg 16,590	Total 111,335 Cash 1836 Supplies 109,499
23.	Dara salam Comm CBO	PHC/EPI School and MCH(EPI, cold chain)	4/00 – 3/01	S&C Awdheghe district L/ shabelle	Total 10,000 U5 yrs – 1,700 U1 yr – 400 WCBage 2,300 Preg 400	Total 19,392 Cash 4,490 Supplies 14,902
24.	Bardera Dis. H/authority CBO	PHC/EPI/Nut	4/00 – 3/01	S&C Bardera dist (Gedo region)	Total 40,000 U5 yrs – 6,800 U1 yr – 1,600 WCBage 9,200 Preg 1,600	Total 17,898 Cash 7,500 Supplies 10,398
25.	Hamar Jab Jab	PHC/EPI	4/00 – 3/01	S&C	Total 32,000 U5 yrs – 5,440	Supplies 10,837

	Comm CBO	MCH in Mogadishu slum		Hamar Jab Jab dis.(Banadir reg)	U1 yr – 1,280 WCBage 7,360 Preg 1,280	
26.	Zam Zam foundation Local NGO	MCH /poly clinic	4/00 – 3/01	Hawl wadag dis. Banadir region	Total 30,000 U5 yrs – 5,100 U1 yr – 1,200 WCBage 6,900 Preg 1,200	Supplies 9,827
27.	Waberi comm CBO	PHC/EPI 1 MCH,EPI	4/00 – 3/01	S&C Waberi dis. Banadir reg	Total 23,526 U5 yrs – 4,000 U1 yr – 941 WCBage 5,410 Preg 941	Supplies 9,705
28.	Hanano local NGO	PHC/EPI	4/00 – 3/01	S&C Hodan dis –Banadir reg	Total 24,450 U5 yrs – 4,156 U1 yr – 978 WCBage 5,623 Preg 978	Supplies 8,558
29.	Awdhegle Dist. Comm CBO	PHC/EPI 1 MCH	7/00 – 12/00 4/00 – 3/01	S&C Awdhegle district L/ shabelle	Total 15,500 U5 yrs – 2,550 U1 yr – 600 WCBage 3,450 Preg 600	Supplies 7,935
30.	Keynan Child Clinic- Private	EPI and EPI plus	4/00 – 3/01	S&C Hawl Wadag dis – Banadir reg	Total 10,000 U5 yrs – 1,700 U1 yr – 400 WCBage 2,300 Preg 400	Supplies 3,106
31.	Wajid Health Authority CBO	PHC/EPI/Nut MCH centre, cold chain,	4/00 – 3/01	S&C Wajid dist – Bakool reg	Total 40,000 U5 yrs – 6,800 U1 yr – 1,600 WCBage 9,200 Preg 1600	Total 16,026 Cash 4,490 Supplies 11,536
32.	Bossaso H/Auth Reg H/Auth	PHC bossaso dist	5/99 – 8/99	NE Bossaso dist – Bari region	Total 23,464 U5 yrs – 4,692 U1 yr – 704 WCBage 5,162 Preg 939	Total 4,570 Cash 1,505 Supplies 3,064
33.	MunaZamat al Dawa Al Islam Int	PHC/EPI 2 MCHs	4/00 – 3/01	S&C Afgoi dist(L/shabelle reg) Shibis dist(Banadir reg)	Total 65,000 U5 yrs – 11,050 U1 yr – 2,600 WCBage 14,950 Preg 2600	Supplies 25,752
34.	Ayub/WFL Int	H/P and Nut 1 H/P and Nut prog in AYUB orphanage	4/00 – 3/01	S&C Merka dis L/Shab reg.	Total 10,000 U5 yrs – 1,700 U1 yr – 400 WCBage 2,300 Preg 400	Supplies 1,996
35.	Hamar Wein Comm CBO	PHC/EPI MCH	4/00 – 3/01	S&C Hamar Wein dist(Banadir reg)	Total 24,450 U5 yrs – 4,156 U1 yr – 978 WCBage 5,623 Preg 978	Supplies 9,215

Annex 3: Key Informants Interviewed

Name	Organisation	Position
NAIROBI		
Mr. Marco Corsi	UNICEF-Somalia	M& E officer
Dr Roberto Bernardi	UNICEF-Somalia	In Charge-Health & Nutrition
Mr Leivean Dosomer	UNICEF-Somalia	EPI- in charge
Ms Karrie Goeldner	USAID	In charge-Development grants
Ms Mia Beers	USAID	Africa Regional Director
Dr Basil King	AMREF	Director – Som. Programme
Julius Tome	AMREF	Lab. Tech-Luuq Hospital, Gedo Region
Dr Vivian Erasmus	AAH-Aktion Africa Hilfe	Medical Co-ordinator
Dr Malweyi	MSF- Holland	Medical Co-ordinator
Michael Marlet	MSF – Holland	Kalazar co-ordinator
Joselyne Madailene	MSF – Spain	PHC Co-ordinator
Dr Emanol Berocotexea	SACB	Chairman –Health Co-ordination Committee
Ms Georgina Platt	International Medical Corps	Country Director-Somalia
SOUTH AND CENTRAL ZONE		
BAIDOA		
Mr Jonathan Veitch	UNICEF-Somalia	Resident Project Officer
Ms Aisha Omar Maulana	UNICEF-Somalia	Health & Nutrition Consult.
Mrs Bertha Jackson	UNICEF-Somalia	Project Officer-Nutrition
Dr Mulegeta	UNICEF-Somalia	Health Consultant
Mr Abdulkadir Huddo	UNICEF-Somalia	Nutrition Consultant
Dr Tahlil	UNICEF-Somalia	Training focal point
Ms Istalin Abdulahi	UNICEF-Somalia	Project Assist.(H& N)
Dr Ahmed Jamaa Musa	International Medical Corps	National Co-ordinator
Mr Abdulahi	International Medical Corps	Administrator
Mr Mohamed Haji	International Medical Corps	Nat. PHC Co-ordinator
Ms Naomi	International Medical Corps	PHC Co-ordinator
Dr. Ali Abdi Ahmed	Somalia Red Cross Society	Health officer
Mr Hassan Ali	Somalia Red Cross Society	Operations Officer
Mr Peter Wangai	World Vision	Project Co-ordinator
Aisha Mohamed	Adada MCH IMC supported	MCH in Charge
Aisha Issa	Adada MCH	Nurse
Yonis Yusuf Sal	Adada MCH	Auxiliary Nurse
Muqtar Mohamed	Adada MCH	Auxiliary Nurse
Idil Abdi Shire	Adada MCH	Auxiliary Nurse

ANNEX 3

Hassan Abdu	Degror Medical Organisation	Nurse In charge
Mariam Haji	DMO MCH	Nurse/midwife
Fatma Mohamed	DMO MCH	ANC nurse
Rosa Ibrahim	DMO MCH	Auxiliary Nurse
Hindi Mohamed	DMO MCH	Auxiliary Nurse
Mustafa Ali Isaac	DMO MCH	Auxiliary Nurse
Asili Ali	DMO MCH	Auxiliary Nurse
Habiba Ahmed Mohamed	SRCS MCH	Nurse in charge
Abdukadar	SRCS MCH	In charge of OPD
Farhiya Mohamed	SRCS MCH	Auxiliary Nurse
Volunteer trainees	SRCS MCH	Total 7
Sharif Mohamedali	Clinic supervisor	TB clinic
Hajia Mohamed	Auxiliary nurse	TB clinic
Abdi Mohamed	Laboratory technician	TB clinic
Isaak. M. Isaak	Auxiliary nurse	TB clinic
HUDDUR		
Ms Sarah	MSF-Belgium KalaAzar wd	Auxiliary nurse
Safia Ali	MSF- Belgium KalaAzar wd	Nurse in Paediatric Ward
RHABDORE		
Abdi Rashid Ahmed	Rhabdore MCH –IMC supported	Nurse in Charge
Adam Hassan	Rhabdore MCH	Nurse
Musalima Mohamed	Rhabdore MCH	Midwife
Yusuf Ahmed	Rhabdore MCH	Auxiliary Nurse
Isaac Kassim	Rhabdore MCH	Auxiliary Nurse
Mahmoud Mohamed	Rhabdore MCH	Auxiliary Nurse
BURHAKABA		
Awaes Issa	MCH supported by World Vision	Nurse in Charge
Isha Abdullahi Mohamed	World Vision	Midwife
Issa NurMohamed	World Vision	Nurse
Hussein Abdi Adan	World Vision	Nurse
Abdukadir Abdulahi	World Vision	Nurse
Sido Sher Mohamed	World Vision	Pharmacist
Abdul Noor Sher Kasam	World Vision	Auxiliary Nurse
Sarah Adam Kero	World Vision	Auxiliary Nurse
Amina Hassan Adam	World Vision	Cleaner/ Assistant
MERKA		
Paulo	COSV	HQ Desk Officer – Somalia

ANNEX 3

Magerita Lulli	COSV	Regional Co-ordinator
Bernard Odera	COSV	Health Co-ordinator
Istalin Ashru	COSV	National Co-ordinator
Khatuma Mohamed	COSV	MCH Supervisor
Halima	Women's group, ex UNFPA	Midwife
Mushqila	COSV	EPI Co-ordinator
Guled		
Muhiba Mohamed Dheera	Shalembot MCH-supported by COSV	Nurse in Charge
Hawa Adam Maalim	Shalembot MCH	Nurse
Awiha Hassan	Shalembot MCH	Auxiliary Nurse
Rahmo Mohamed	Shalembot MCH	Auxiliary Nurse
Shukri	Shalembot MCH	Lab Technician
Fadumo Ali Di	Shalembot MCH	Auxiliary Nurse
Shamsa Mohamed	Xurunta MCH –COSV	Nurse
Aisha Ali	Xurunta MCH	Midwife
Mohamed Osman	Waagadi Health Post	CHW
Idris Abdi Hassan	Waagadi Health Post	CHW
Mwana Kassim	Waagadi Health Post	TBA
NORTH WEST ZONE (SOMALILAND)		
HARGEISA		
Dr. Abdi Daahir Ali	MOH&L	Minister of Health
Mr Ahemed Abdi Jamaa	MOH&L	Director General
Dr. Romanos Mkerenga	UNICEF zonal office	Regional Project Officer
Awil Haji Ali	UNICEF zonal office	Project Officer – Health
Mariam Yusuf Fahye	UNICEF zonal office	
Ms. Halima Elmi	Int. Co-operation for Development (ICD)	Development worker
Mr Abdi Gure	WHO	Officer in charge
Dr Campbell	WHO	EPI co-ordinator
Dr Ali	WHO	National co-ordinator EPI
Mr Markdi Dahil	WHO	Logistics officer
Ali Migai Musa	Shiekh Noor MCH	Auxiliary nurse
Adan Osman	Shiekh Noor MCH	Auxiliary nurse
Hodan Omar	Central MCH – Hargeisa	Nurse/midwife
Ibedo Burrutu	Central MCH- Hargeisa	Nurse/midwife
Mr Ali M. Musa	Sheikh Nur MCH – Hargeisa	Auxiliary nurse
Mr. Mohamed Hassan	Sheikh Nur MCH – Hargeisa	Nurse – pharmacy

ANNEX 3

Mr Ahmed Muhan	Bokor Health post	CHW
Ms. Ida	Ida Maternity Home(private)	Nurse/midwife
BOROMA		
Dr Alexandro Brachetti	COOPI	Medical Co-ordinator
Ms Maka Amar	Central MCH	Nurse
Mr Mohamed Yusuf	Central MCH	Watchman/assistant
NORTH EAST ZONE (PUNTLAND)		
BOSSASO		
Dr Hiromasa Nakai	Zonal office	Resident Project Officer
Dr Willis Ouma	Zonal office	Project Officer- Health and Nutrition (H&N)
Dr. A. Yusuf Muse	Zonal office	Asst. Project Officer(H&N)
Ms. Hodan Mire Ismail	Zonal office	Asst. Project Officer(H&N)
Mr.A. Abdullahi Haga	Zonal office	Secretary H&N
Mr Isaie Habimana	Zonal office	PO Operation
Mr Ibrahim Abdi Shire	Zonal office	M&E officer
Dr Assegid Kebede	WHO	Int. focal point – polio
Mr Farah Warsame	Ministry of Social Affairs	Minister of Social Affairs
Eng. M.. A. Kulmiye	Ministry of Social Affairs	Asst. Min.of Social Affairs
Dr. A.S. Mahamud	Ministry of Social Affairs	Director General of Health
Dr. A.J. Abshir	Ministry of Social Affairs	PHC/ Training Director
Mr A. A. Osman	Puntland Development Research Centre	Director
Dr Anthony Abura	AAH	Health Team Leader
Dr A.F. Bashane	AAH	Programme Co-ordinator
Dr Ali Sett	AAH	PHC Co-ordinator(PCO)
Ms Rose Agengo	AAH	PHC Nurse Co-ordinator
GAROOWE		
Sirad Aden Mohamed	Somali Red Crescent Society	Health Officer
Ms Asha.A. Hasan	Garoowe MCH	Midwife
Ms Nadifa.S. Osman	Gaoorwe MCH	Nurse
Ms. Zahra Hassan	Galkacyo MCH	Auxiliary nurse
Ms Haweiya Hussein	Galkacyo MCH	Cold chain assistant

GARDO DISTRICT		
Mr Ali Mohamed	Sherbi PHCU	CHW
Mr A.A. Osman	Yaka PHCU	CHW

ANNEX 3

GLAKACYO		
Mr Joseph Abende	MSF - Holland	Project Team Leader
Dr Simon Burling	MSF - Holland	Project Physician
Ms Afua Berchie	MSF - Holland	Project Midwife